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ABSTRACT

The final report describes the development of a program to train neighborhood mothers as home visitors to families with a handicapped child under age 3. The following program aspects are detailed (sample subtopics in parentheses): population (referral sources, family and child characteristics): staff (changes in staffing pattern, hiring core mothers): staff training (planned inservice training, staff attitudes toward learning): and program services (initial assessment and individual program plan, home visits, respite care). Two concluding sections focus on evaluative information, including an analysis of service utilization data. Extensive appendixes include a case study, descriptions of staff training, and a discussion of selected interventions. (CL)

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D. Handicapped
Infants

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NEIGHBORHOOD SUPPORT SYSTEMS FOR INFANTS

Final Report
July 1976 - December, 1979
OEG No. G0076020802

Bureau of Education for the Handicapped
Office of Education
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Washington, D.C. 20202

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DEPARTMENT OF HEALTH, EDUCATION AND WELFARE
OFFICE OF EDUCATION
WASHINGTON, D.C. 20202

PROGRAM PERFORMANCE REPORT (Discretionary Grants)

FORM APPROVED
OMB NO. 51-R1091

Further monies or other benefits may be, but will not necessarily be, withheld under this program unless this report is completed and filed as required by existing law and regulations *(45 CFR 121, GSA FMC 74-7)*.

Part I

All grantees with awards from programs listed under "General Instructions" above respond.

1. Date of Report: August 31, 1980

2. Grant Number: G 0076020802

3. Period of Report: From: 7/1/78

To: 6/30/79

4. Grantee Name and Descriptive Name of Project:

Neighborhood Support Systems for Infants

Certification: I certify that to the best of my knowledge and belief this report *(consisting of this and subsequent pages and attachments)* is correct and complete in all respects, except as may be specifically noted herein.

Typed Name of Project Director(s) or Principal Investigator(s): Sheila Botein

Signature of Project Director(s) or Principal Investigator(s): Sheila Botein

Part II *("Accomplishment" Reporting)*

A. All grantees, except for those with awards under 13.443 are to respond to this Section A. Grantees under 13.443 go to B of Part II.

All grantees with awards under 13.444 except those supported solely for "Outreach" activities are to follow the organization of categories listed below in presenting their performance reports. The categories are based on activities common to all Early Childhood projects with the exception noted above for projects solely supported for outreach activities.

(1) Direct and Supplementary Services for Children's Services
(2) Parent/Family Participation
(3) Assessment of Child's Progress
(4) Inservice Training for Project Staff
(5) Training for Personnel from other Programs or Agencies
(6) Demonstration and Dissemination Activities
(7) Coordination with other Agencies
(8) Continuation and Replication

The grant application for programs 13.445, 13.446, 13.450, and 13.520 provided for the following functions or activities as categorical headings in the budget and narrative sections:

Research and Development	Dissemination
Demonstration/Service	Preservice/Inservice Training
Evaluation	

Programs 13.451, and 13.452 do not usually require a breakout since the primary function or activity is intrinsic to the respective program.

For each of the above programs, functions, or activities *(as well as those of special import for certain programs; e.g., replication, advisory councils, parent involvement)* discuss the objectives and subobjectives presented in the approved application *(in narrative format)* in terms of:

(a) Accomplishments and milestones met.
(b) Slippages in attainment and reasons for the slippages.

Refer back to your application and utilize your quantitative quarterly projections, scheduled chronological order and target dates, and data collected and maintained as well as criteria and methodologies used to evaluate results for (a) and (b). For grantees under 13.444, in discussing training or personnel from other programs, include descriptions of types of training, institutions or organizations involved, and numbers of trainees and hours of training received.

Also highlight those phases of the plans of action presented in your application that proved most successful, as well as those that upon implementation did not appear fruitful. NOTE: Outreach grantees are to discuss accomplishments and slippages in terms of replication and stimulation of services, resources provided and field testing and dissemination and training in terms of types of personnel receiving training and the number of hours involved.

Grantees finishing this portion of Part II, go to C of Part II.

B. Reporting for Grantees under 13.443 *(Research and Demonstration)*.

Discuss major activities carried out, major departures from the original plan, problems encountered, significant preliminary findings, results, and a description and evaluation of any final product. Either include copies of, or discuss information materials released: reports in newspapers, maga-

SEP 22 1980

zines, journals, etc.; papers prepared for professional meetings; textual and graphic materials; completed curriculum materials and instructional guides, or drafts if in a developmental stage, special methods, techniques and models developed; scales and other measuring devices used.

When finished with this portion of Part II, 13.443 grantees go to C of Part II.

C. All grantees are to respond to this section C. Discuss the following:

(1) Unanticipated or anticipated spinoff developments *(i.e., those which were not part of your originally approved subobjectives, but which are contemplated within the purpose of the Education for the Handicapped legislation, such as new cooperative inter-agency efforts, a decision by volunteer(s) to pursue a career in special education, new public school policy to integrate handicapped children into regular classrooms, enactment of mandatory or other State legislation affecting early education, relevant new course offerings at universities, etc.).*

(2) Where outputs are quantified in response to any portion of Part II, relate quantifications to cost data for computation of unit costs. Analyze and explain high-cost units.

(3) Indicate other matters which you would like OE to know about *(e.g., community response to the project, matters concerning the project's working relationship with OE, technical assistance of OE staff, or any other relevant subject.).*

Part III

All grantees with a Demonstration/Service function or activity, except for 13.444 grantees who are solely supported for "outreach" activities, are to complete Tables IA, IB, and IC. All grantees under 13.451, as well as those under other handicapped programs with a Preservice/Inservice Training activity are to complete Table II. All grantees under 13.444 except those who are supported solely for "outreach" activities, are to complete Tables IIIA and IIIB.

Table IA – Demonstration/Service Activities Date
Children

Enter actual performance data for this report period into the appropriate boxes. Use age as of the time of the original application, or the continuation application, whichever is later. On lines above line 11, count multihandicapped individuals only once, by primary handicapping condition, and indicate the number of multihandicapped in line 12. Data for lines 1 through 11 are for those directly served; i.e., services to those enrolled or receiving major services, and not those merely screened, referred or given minimal or occasional services.

Type of Handicap	Number of Handicapped Served by Age					
	Ages 0-2	Ages 3-5	Ages 6-9	Ages 10-12	Ages 13-18	Age 19 and Over
1. Trainable Mentally Retarded	2					
2. Educable Mentally Retarded	2	1				
3. Specific Learning Disabilities	11					
4. Deaf-Blind						
5. Deaf/Hard of Hearing						
6. Visually Handicapped	1	1				
7. Seriously Emotionally Disturbed	3					
8. Speech Impaired	6	3				
9. Other Health Impaired	12					
10. Orthopedically Impaired	11					
11. Total	48	5				
12. Multihandicapped	4	3				

If the data in the above table differ by more than 10 percent from the data originally presented in your approved application, please explain the difference.

Table IB
Project Staff Providing Services to Recipients in Table IA

Type of Staff	Number	
	Full-time	Part-time (*As Full-time Equivalents*)
Professional Personnel (*excluding teachers*)	2	1
Teachers		
Paraprofessional	4	1

Table IC
If applicable: Services to Those Handicapped Not Included in Table IA

Service	Number of Handicapped
Screened	
Diagnostic and Evaluative	
Found to Need Special Help	
Other Resource Assistance	

Table II
Preservice/Inservice Training Data

Handicapped Area of Primary Concentration	Number of Persons Received Inservice Training	Number of Students Received Preservice Training by Degree Sought			
		AA	BA	MA	Post MA
Multihandicapped					
Administration					
Early Childhood	3	3			
Trainable Mentally Retarded					
Educable Mentally Retarded					
Specific Learning Disabilities					
Deaf/Hard of Hearing					
Visually Handicapped					
Seriously Emotionally Disturbed	5	3			
Speech Impaired					
Orthopedically and Other Health Impaired	2				
TOTAL					

If data in Table II above differ by more than 10 percent from those in your approved application, explain.

Table IIIA
Placement of Children Participating in Early Childhood Program During Reporting Period

Indicate the placement of children who left your project during the year covered by this report period.
NOTE: Count each child only once by primary type of placement below.

TYPE OF PLACEMENT			NUMBER OF CHILDREN	
			FULL–TIME	PART–TIME
INTEGRATED PLACEMENT *(i.e., in regular programs with children who are NOT handicapped)*	Nursery schools		1	
	Day-care programs		1	3
	Head Start		1	1
	Pre-kindergarten		8	
	Kindergarten			
	Primary grades	First		
		Second		
		Other		
SPECIAL EDUCATION PLACEMENT *(i.e., in classes only for handicapped children but situated in regular private or public school)*	Pre-kindergarten			
	Kindergarten			
	Primary grades	First		
		Second		
		Other		
INSTITUTIONAL PLACEMENT	Scheduled to remain in Early Childhood Program in coming year			
	Other *(specify)*			

Table IIIB

Cumulative number of children entered into integrated placement *(if known)* prior to this report period →	NUMBER	Estimated retention rate of cumulative number in integrated placement →	PERCENT %

ACKNOWLEDGEMENTS

The report has been written by several people over ten months time. Cynthia Koerber was responsible for collecting, recording and organizing the data that is reported. Donna Karl wrote the section on Staff Training and compiled the training catalogue in the Appendix. Martha Niebanck contributed the case study and annotated the interventions that are included in the Appendix. Anne Coolidge wrote the Project Evaluation and edited the rest of the report. Sheila Botein wrote the remaining sections and was responsible for organizing the whole effort. Dorothy Donovan-Kaloust typed several drafts. Since everyone who staffed NSSI during the period of the federal funding has contributed to the development of the model it is improtant to acknowledge their roles and the period of their involvement.

Sheila Botein, Director, 1976 -
Donna Karl, Pediatric Nurse Practitioner, 1976 -
Martha Niebanck, Occupational Therapist, 1976 -
Anne Coolidge, Project Evaluatior, 1978 - 80
Victoria Leonard, Administrative Assistant, 1977 - 1978
Cynthia Koerber, Administrative Assistant, 1978 - 1980
Dorothy Donovan - Kaloust, Parent Coordinator, 1978 - 1980
Patricia Lane, Core Mother, 1976 - 1979
Catherine Skiffington, Core Mother, 1976 - 1979
Barbara Regan, Core Mother, 1976 - 1978
Frances Ghidella, Core Mother, 1976 - 1978
Bonnie Di Orio, Core Mother Alternate, 1976 - 1977
Martha Botelho, Core Mother, 1976 - 1977
Maria Arruda, Core Mother, 1978 - 1979
Jean Hiltz, Core Mother, 1978 -
Barbara Lavey, Core Mother, 1978 -

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INTRODUCTION

This is the final report submitted to the Bureau of Education for the Handicapped about Neighborhood Support Systems for Infants, an HCEEP demonstration project in Somerville, Massachusetts, which officially ended on June 30, 1979, although unexpended carry-over funding supported some work until December 31, 1979. Federal funding was not used here to develop auxiliary services but instead to develop a completely new and independent program. Happily, NSSI services continue after federal dollars have stopped although the search for local funding has taught us why new demonstration projects may be regarded with suspicion by health and human service providers as well as by clients.

The report that follows describes how efforts to respond to the needs of both providers and clients in our community influenced the development and the delivery of our services. Of course, we were unable to respond to all their needs; initially, we were unprepared for the variety of requests that would be presented to a small, flexible staff with new federal funding. Since few services existed for infants and their families, NSSI was expected to respond to a large but incompletely identified need. This report details our efforts to balance innovation and responsibility; our own priorities and our perception of the government's; documentation of a model and provision of a service.

Central to the NSSI model are mothers who are hired and trained as home visitors to families which include a handicapped child under three. Many education programs, notably Headstart, had demonstrated some of the advantages of paraprofessional staffing and NSSI's experience also shows the particular strengths that non-professional women can bring to a home-based, family focused early intervention program. In this report we describe how we defined an autonomous and flexible role for NSSI home visitors, called Core Mothers, which combines support for their own insights and intuitions with professional supervision. The process of defining staff roles in a program where services are individualized and responsive has been neither speedy nor clear-cut. It has, however, yielded many insights about the nature of early handicapping conditions, about their impact on families and about the purposes of early intervention. New projects aiming to serve unfamiliar clients must view their initial efforts as exploratory and subject to revision. NSSI staff have certainly learned as much as the designated target group, and we hope that the story of our work with families and children may inform BEH about the latitude that new programs need.

The organization of the report is straightforward: it introduces the sponsoring agency, the clients and the staff before discussing the training, the services and the evaluation. We have tried to balance concrete details about the day to day implementation of NSSI's services with discussion of the broader questions to which we have often returned and which we hope are of concern to anyone who is interested in supporting parents and their very young children.

I. Project History

A. Programmatic Precursors

Paraprofessional staffing has been a central component of Neighborhood Support Systems for Infants from the time the initial application for funding was made to the Bureau of Education for the Handicapped. Thus, we have decided to review briefly the reports of social service programs which have hired indigenous paraprofessionals because their experience suggests themes that are relevant to ours.

Many programs initiated during the War on Poverty in the 1960s saw paraprofessional staffing as a cost-effective means to simultaneously reduce unemployment and reach previously unserved clients. Their planners assumed that workers from the targeted community are not only more accurate than professionals in assessing the community needs[1] but often are more successful in soliciting utilization of available resources.

For instance, an immunization program in Oklahoma reported in 1967[2] that indigenous paraprofessionals brought in 2 000 patients per month to the clinic as opposed to the three public health nurses who had, three years prior, only been able to recruit an average of 900 patients per month.

In this and in other programs, the paraprofessionals worked as auxiliaries to individual professionals, like nurses or social workers, and were primarily responsible for discrete tasks such as weighing and measuring babies. In this respect they are quite different from Core Mothers in NSSI, who have considerable autonomy although they are supervised by an administrative staff that is professionally trained.

Clearly, characterizations of paraprofessional style are, at best, suggestive. Our own experience with nine different Core Mothers has pointed out how difficult it is to distinguish which behaviors reflect an individual's own style and which are more generally characteristic of the role. Forewarned, we can review current assumptions.

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[1] Charles Crosser, "Role of non-professional in the Manpower Development Program," Department of Labor, Washington, D.C., 1966.

[2] James Stewart, Employment of Indigenous Personnel and Strategy for Increasing Immunization Rates in Hardcore Areas," Norman, Oklahoma, U. of Oklahoma Press, 1967.

It is often hypothesized that paraprofessionals can be effective "bridgemen" between professional staff and the community because they establish and maintain contact more easily than educated middle-class professionals. The assumption is that professionals and low-income clients both have biases about each other that may inhibit a working relationship. The literature frequently reports that, in contrast to the professional, the paraprofessional seems "less formal" in dress, language and interpersonal style.[3]

In assessing a client's needs, a paraprofessional may react more to external than internal factors. Thus, a situation perceived by the professional as "neglectful" may be interpreted by the indigenous worker as a reaction to "depressed conditions."[4] It is surmised that paraprofessional workers are less impressed with underlying psychological problems because they identify more readily with the client, and may see him as a victim of forces beyond his control, who is unable to maneuver within the medical, educational or social welfare system.

In "A New Approach to the Social Work Technician," George Brager describes the unique potential of paraprofessionals:

> The non-professional has no need to validate his presence in the community. Because of what the indigenous non-professional _is_, there are things he can _do_ which the professional is not able to do and should not do...Even professionals who have excellent relationships skills are limited by the value of their functions as an "expert." This definition of role, which they and the poor both hold, prevents the development of a fully rounded everyday relationship...The indigenous worker can play a more flexible role because there is no set definition of how he must act. When a professional will 'suggest' and 'enable,' the non-professional is 'in the center' of activity...training by demonstration and providing direction.[5]

---

[3] Robert Cohen, _New Careers Grows Older: A Perspective on the Paraprofessional Experience_, ITH Press, Baltimore, 1976.

[4] George Brager, "Mobilization for Youth: The Low-Income Non-Professional: An Overview of this Role in the Program," HEW, Office of Education, New York, 1964.

[5] _Social Work_, April, 1965.

Clearly, some employers and planners have chosen to employ non-professionals as adjuncts to individual professionals. Their contacts within a community help bring new clients to the professionals they work alongside. Others, including Mr. Brager, above, suggest that non-professionals can have a more comprehensive role in service delivery, and that much of the strength of the role rests in its flexibility and its lack of professional definition. Two educational intervention programs that used non-professional indigenous workers apparently combined structure and independence in their role. Both Ira Gordon's program in Gainesville, Florida and Alice Honig and Ronald Lally's Syracuse program used teaching assistants who spent some time in a classroom alongside a teacher and some time in homes working by themselves with mothers and their children.

Our impression is that evaluation of programs that use paraprofessionals is scarce and inconclusive. Problems with the use of para-professionals frequently cited are non-acceptance by outside professional community, inadequate reimbursement for their services at all levels but particularly for those who choose to remain in programs, and the lack of the development of an adequate career ladder[6] within the program so that the paraprofessional is not stuck in an entry level position. An important question relating to concerns about motivating non-professional workers is whether tenure in a program diminishes or, at least, changes one's non-professional status. Should programs which hire non-professionals develop training components that are competency-based and that award college credit so that workers' job mobility is not entirely based on their experience?

At NSSI we have not developed satisfactory answers to many of these questions, although they have provoked us continuously. In this report, we describe the essential characteristics of our service delivery during the period of federal funding, but since our program will continue, we look forward to resolving the more enduring questions as we gain more experience.

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[6] Cohen, op. cit.

B. Agency Sponsorship

Neighborhood Support Systems for Infants was established in July, 1976 after the local Head Start director, a program planner from the sponsoring community action agency, and a guidance counselor submitted a successful application for demonstration funding to the Bureau of Education for the Handicapped.

In retrospect, it may be worth noting that none of the authors of the original proposal were parents, none of them had experience with infants or with specialized educational services, and only one, the guidance counselor, had a role in the actual project. She worked part-time for the first four months.

The original proposal describes a decentralized, neighborhood-based support system with Core Mothers working in their own homes with their clients much of the time. Because they were envisioned as the "core" of a neighborhood support system, the hired parents were designated as "Core Mothers." The proposal described how, during the three years of demonstration funding, NSSI would become integrated into the Somerville Head Start Program and would apply for Office of Child Development monies in order to continue its services.

It is interesting to note that NSSI was the last large grant awarded to Eastern Middlesex Opportunities Council (EMOC), a Community Action Agency with a history of sloppy financial administration. The instability of the agency meant that the new project suffered from incomplete fiscal information during its first year of funding, but it also meant that the project gained programmatic autonomy since everyone in the agency and on the board was preoccupied with EMOC's survival. Their efforts failed and EMOC was defunded by the Community Service Administration (CSA) in August 1977. At this point, NSSI staff separated from the Head Start program and sought sponsorship from the Mental Health and Retardation Center of Cambridge and Somerville, Inc. (Center, Inc.). Affiliated at the area level with the Massachusetts Department of Mental Health, this small agency offered orderly fiscal management and closer connections with clinical staff of the preschool program for children with special needs.

II. Project Population

A. Referral Sources and Growth of Caseload

NSSI has accepted a substantial number of self-referrals in addition to referrals from individuals affiliated with 20 different institutions aimed to improve the health, education or social welfare of their clients. Since initially we did not record referrals who were not accepted, we can only say that from more than one hundred and thirty-two families referred between 12/76 and 6/79, we have accepted eighty-seven children from eighty-four referrals (two twins and one pair of siblings were referred simultaneously). A complete list of referral sources may be found in the appendix. We can divide the accepted referrals into categories as follows:

Referral Sources for Accepted Cases, NSSI, 12/76-6/79

Social Service/ Mental Health	Medical Providers	Self	Educational Programs
28	25	19	12

So, one-third of our accepted referrals are from public or private social welfare agencies of hospital Social Service departments; 30% of our clients are referred by physicians and nurses (25% from Somerville Hospital and its affiliated clinics); 23% of NSSI families can be characterized as self-referrals and 14% of our referrals are from preschools and neighboring early intervention programs.

More than 90% of the accepted referrals were made by service providers or individuals in Somerville, Cambridge, or Medford; 73% from citizens and providers in the city of Somerville itself.

We are frankly surprised by the number of self-referrals we have received, although it is not surprising that the number has risen slightly each year. In order to assess our outreach efforts we have tried to find out where people who called to refer themselves had learned about NSSI. For instance, NSSI staff have periodically visited the city halls of Somerville and Medford to stand alongside baby photographers and diaper distributors copying down the names on the new birth records. A congratulatory letter and a copy of our brochure was sent to the parents of 1500 new babies in the two original target cities. Sometimes, families who received the letter told a friend.

The Source of Self-referrals

	Total	Neighbor/ Friend	Letter	NSSI Parent	Flyer, news-paper article
Year I (12/76-6/77)	4	3	1	0	0
Year II (7/77-6/78)	7	0	4	1	2
Year III (7/78-6/79)	8	4	1	2	1

Most (60%) of the self-referrals reside in Somerville, although it is interesting to note that a substantial portion (41%, or five out of twelve) of the Medford families in NSSI were self-referrals.

B. Residence Criteria

Between December, 1976 and June, 1979, NSSI has provide services to 87 children in 82 families in five cities. Most client families live in Somerville, a densely populated (2½ sq. miles, 88,000 people) working class suburb of Boston. Heavily Catholic, largely white, and historically Irish and Italian, the city's population has recently been augmented by a substantial Portuguese community (12%) and a smaller Haitian and Spanish community. NSSI has served a scattering of families in the adjacent cities of Meford, Malden, Everett and Cambridge--many of whom are referred by Somerville health and social service providers. The first three cities are smaller, somewhat more affluent and without a network of services, while Cambridge is larger and more heterogeneous economically and socially.

The chart below illustrates that both the number and the proportion of Somerville families has risen. We assume this reflects a more active referral network, the presence of our office in that city, and, perhaps, greater need. It also reflects how much a new program is dependent on the satisfaction of referral sources since many of the Somerville families were referred by one source, Somerville Hospital.

City of Residence of NSSI Families

Project Year	Somerville	Medford	Cambridge	Malden	Everett	Total
I 12/76-6/77	12	4	1	1	--	18
II 7/77-6/78	19	6	2	1	--	28
III 7/78-6/79	32	1	2	--	1	36
Total	63	11	5	2	1	82

C. Characteristics of Families Who Have Received Services

In this section we are relying on information collected between 12/77 and 6/79, during our initial contacts with 82 families (including 87 children).

Most families in NSSI can be characterized as "working class." Of the 82 families accepted for services between December, '76 and June, '79, 44 (54%) are supported by the Massachusetts Department of Public Welfare. Of the others, almost 10% have had their jobs terminated and are collecting unemployment. When family members do work, their wage-earning capacity is often seasonal, insecure, or in jobs which have no benefits. Less than 15% have jobs that are stable, such as university maintenance work, postal work, restaurant management.

Most NSSI parents are American-born (86%), and are Caucasians of Italian or Irish origin (91%). They include, however, a varied ethnic minority with mothers and fathers who were born in Portugal, Puerto Rico, Italy, Costa Rica, Haiti, Argentina, El Salvador, Uruguay, Greece, Honduras, Korea, and Hungary. Racially, the group is less heterogeneous, with 5% Hispanic parents, 2.8% Black parents (Haitian and Afro-American), and 1.4% Oriental parents.

NSSI mothers have ranged from 15 to 43 years when they had their NSSI child, with an average age of 25 years. 18% of the mothers were age 19 or younger. Eighty-five percent of this subgroup were supported by public welfare and over seventy-five percent of the young mothers were unmarried.

We have only collected data on mothers' educational level since that is often seen as predictive of childrens' developmental level.

NSSI Mothers' Education

	Grade Completed				
	6th	7th-9th	10th-11th	12th	12th+
No. of Mothers	5	16	25	33	3
% of the total group of mothers they represent	6%	20%	30%	40%	4%

More than a quarter of the mothers did not enter senior high school which begins in the tenth grade and almost half of the group that entered did not graduate. Our impression is that departure from school does not coincide with child-bearing--the average NSSI mother had her baby when she was in her early twenties. School dropout does, however, reflect widespread disaffection with local secondary education facilities.

We have been impressed with the high percentage of women who are solely responsible for their young children.

NSSI Mothers' Marital Status

	Married	Single Never Married; separated or divorced	Single with Partner
# of mothers	43	33	6
% of total mothers	52%	40%	8%

We assumed that a resident man might provide some direct assistance with child care and might also provide emotional support to the mother that would make it easier for her to nurture her children. We know, however, that relationships between married and non-married partners were often uneven and disappointing, but since our records are impressionistic and anecdotal we do not know what effect relationships between adults had on children's development in NSSI families.

While many women may be offered both emotional and tangible assistance from extended family, especially from their own mothers, others may be unable to acknowledge or accept this support. The discrepancy between what was anticipated and what is experienced in child-rearing can be troubling and new mothers may be reluctant to share negative feelings with their own parents. Occasionally, however, mothers lived with extended family. Our impression is that this was most helpful with very young mothers and new babies. Sometimes, too many resident extended family members are confusing and draining; in one family, two adolescent sisters were alternately helpful and competitive, supportive and then undependable while in another family the NSSI mother was responsible for her two adolescent brothers as well as her husband and two small children.

Current efforts that are underway in other programs (Uri Bronfenbrenner, Cornell; Michael Berger, Georgia State) to assess, record, and, perhaps, effect extended family supports may be useful. In retrospect we wish we had had access to a methodology for collecting this data since our impression remains that available family support can make a difference in how easily a mother is able to negotiate both developmental and environmental crises.

In the discussion of characteristics of our referrals, we noted that during the first quarter of the second year NSSI received an increasing number of referrals for parenting. Given our resources and assessment of the families' motivation, we decided that we could offer a short term, finite involvement. Short-term cases have accounted for one-quarter of our accepted referrals and more than half of the families assigned to Category III, environmental risk. Since many of the families referred for support had multiple problems and were familiar to the social service agencies in Somerville, NSSI set goals that would focus involvement on the young child in the family. Initially, we planned ten weekly visits, or a 2½ month intervention. By the third year we had become convinced that four to six months was a more realistic timetable for short-term involvement. In short-term cases, we may focus on connecting a family with other resources, as well as providing information to mothers about child development and childcare options and our experience suggests that two and a half months is too short and gives us little opportunity to see whether a mother can follow through with our recommendations.

Using the same characteristics that we identified above for the entire caseload, short-term clients seem more apt to be isolated, poor and less well-educated.

NSSI Mothers' Marital Status
Short-term and Long-term Clients

	Married	Single Never Married; separated or divorced	Single with Partner	Total
Short-term Clients	8 (36%)	12 (55%)	2 (9%)	22 (100%)
Long-term Clients	37 (57%)	22 (34%)	6 (9%)	65 (100%)

It is not surprising that a significantly higher percentage of mothers whom we designated as short-term clients are single parents since we know that the caretaking and dependency needs of an infant or toddler are demanding and apt to be stressful for a single adult.

If we consider that lack of education adds an additional stress that makes it more difficult for a young woman to find employment, it is noteworthy that seven of these mothers (39%) have not gone beyond junior high school and thirteen of them (72%) have not completed high school. These two categories are 50% larger than they are in the overall population of NSSI mothers.

Two-thirds of the client families in short-term cases are supported by public welfare compared to just under half of the long-term clients. In addition, the mothers tended to be younger when they had their NSSI child; the average age for NSSI mothers is 25 years, while short-term mothers average 23 years at the birth of their NSSI child. These mothers may acknowledge that behavior problems their children present may be a result of their uncertainty about how to respond to them; the children in short-term cases are typically first-born, only children and as such present more anxiety to their inexperienced mothers than the children in long-term cases. They also tend to be somewhat older (16 months) at referral than the long-term children. whose average age at referral is just under a year.

Indeed, most of the early short-term cases seemed to be young, isolated mothers who had managed adequately for the first year of their child's life but who found the independence of a young toddler impossible to cope with. The content of the short-term cases will be described later in the discussion of program services.

One additional way of learning about NSSI families is to consider the subgroup who have been reported by the filing of a 51A* to the Massachusetts Department of Public Welfare (DPW) because they are suspected of abusing or neglecting their children.

Seventeen families which include nineteen children have received 51A's; thirteen of these were filed before the family became involved with NSSI. NSSI staff filed one of the four 51A's that were registered after our involvement with the family because there was no other way for the mother to receive social service counselling from the agency of her choice.

Overall, parents who have received 51A's are poorer, more isolated and less well educated than other NSSI parents. Fourteen of the seventeen families (82%) are supported by AFDC from the Department of Public Welfare; ten of the families (59%) are separated and the mothers live alone with their young children. Seven of the seventeen (41%) mothers had no formal education beyond junior high school and ten (59%) have not completed high school. The mothers ranged in age from 17 to 38 years at the birth of their NSSI child; their average age was 23 years, which is two years younger than the average age of mothers in the total NSSI population.

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* Sect. 51A of Massachusetts Public Law Chapter 119 mandates certain reporters and enables all citizens to refer such allegations to the state Department of Public Welfare.

Seven of the mothers had older children and the average age at which mothers in this group had their *first* child is 21 years but, if we exclude the one mother in her thirties, the average age at which the remaining sixteen mothers had their first child is just 20. Almost two-thirds (63%) of the children in this group were first-born compared with 39% of the children in the total NSSI population.

Four of the families who received 51A's were also initially designated short-term clients, so there is some overlap between the two subgroups. Considering the profile of each subgroup, it is not surprising that the group who received 51A;s appear needier according to these external, relatively objective criteria: they are younger, poorer, and more isolated. Although we did not collect and compare data about mothers' memories of their own childhoods, our impression is that this information would be quite different for the two groups and that the mothers who received 51A's would have experienced significantly more deprivation themselves.

We have assigned thirteen of these families to Category III, environmental risk and we have also considered thirteen to be long-term clients while four were designated short-term. Perhaps because of the 51A, families are entitled to certain supportive services that will be paid by the department of public welfare, it is not surprising that NSSI functioned as an intermediate service for nine of the children who ended up in some kind of day care and also for five who were finally placed in temporary foster care.

D. Child Criteria

Between December 1976 and June 1979, we have altered our criteria for children, first in response to federal recommendation and later in response to pressure from local referral sources. NSSI's initial application proposed services to children who were handicapped or who were at risk for emotional and developmental delays because their parents were drug addicted, alcoholic, mentally retarded, psychotic, chronically criminal, or abusing. However, at the orientation meeting for new project directors, several BEH representatives stated clearly that children served by demonstration projects must be identified handicapped. In addition, the responsibility for documenting each child's handicap was presented as an essential component of the evaluation of each project's services to children. It may be worthwhile to record the reaction of NSSI's administrator to the confusion about who was eligible for federally-funded intervention services. Had NSSI staff been more experienced with either federal grants or handicapped infants, we might have felt the Bureau's recommendation could be discussed and possibly revised on a program by program basis. As it was, however, like many inexperienced recipients of federal grants, we felt obliged to disregard our initial criteria, in order to comply with BEH's directive and accept only children with identified handicaps--either sensory deficits, physical anomalies, or clear developmental delays. Either the clinical impression of the referral source or the results of our initial assessment would provide documentation.

Our resolution to accept only children with intrinsic disabilities or documented delays was tempered by several different experiences. First, as we found out more about the etiology of various handicapping conditions, we learned that many disabilities that handicap development during the preschool years are not obvious during infancy. "Soft" signs like persistent irritable crying, difficult feeding, or failure to maintain eye contact may trouble an experienced mother or may raise questions in the mind of an observant pediatrician but they are unlikely to prompt a referral to an early intervention program. Since such soft neurologic signs rarely appear in isolation but rather combine to form unusual behavior patterns that may make nurturing difficult, a home visitor can, at the very least, support the mother and observe the baby.

Second, we became aware of longitudinal studies (e.g., Werner's Children of Kauii) which suggest that low socio-economic status may exacerbate a high medical risk and increase the likelihood of an undesirable outcome. Although we knew that the majority of high risk babies develop normally, there is clinical evidence that supports offering services to families which include difficult, high risk infants. Third, during the second year of our funding, BEH not only supported more infant programs but funded several that plainly characterized their target population as high risk for developmental disorder.

Added to the clinical evidence, longitudinal studies and the Bureau's flexibility were the requests of referring institutions in our area. Once they had accepted our project, made referrals, and experienced satisfaction, they wanted to refer other families with very young children. They characterized these families as temporarily or chronically unable to nurture their children because the parents were either developmentally delayed themselves, or stressed and unable to cope. Health providers and social workers wanted to know why we could not intervene preventively. Except for a very limited number of family day care slots, there were no services in our area for these families. As a new program, we felt some obligation to respond to these pressures. Soliciting "appropriate" referrals had not been easy. Not only had potential referral sources articulated the traditional hesitation to label infants as handicapped but they also expressed confusion and uncertainty about our innovative model. We were dependent on local sources since intensive care units in Boston hospitals were even more reluctant to refer a new early intervention program that was sponsored by a Community Action Program and staffed by paraprofessional mothers. In sum, problems in certifying handicap in very young children combined with requests from local referral sources as well as our own readiness to provide a 'useful" community service resulted in our enlarging our criteria to include some families in which parents were unable to care for their children appropriately and in which children were at risk of developmental delay, abuse or neglect.

E. Characteristics of the Children Who Have Received Services

We have divided our caseload into three major categories according to information we learn about the child at the time of referral. Each major category includes five or six subgroups which represent a more detailed classificaton based on the target child's diagnoses. Category I comprises those children who are referred with fixed diagnoses, while Category II includes children who are in need of services because of perinatal events or because of subsequent developmental anomalies and Category III includes children who are primarily at risk because of their home environment. According to the useful criteria recently developed by the Massachusetts Early Intervention Consortium, the children in Category I are at "established risk," those in Category II are at "biologic risk," and those in Category III suffer from "environmental risk." Children have been placed in groups according to how they have been served by NSSI. Therefore, Group III includes a few children with serious physical disabilities who may have received physical therapy from another source but who were referred to NSSI because they were at risk for abuse or neglect. The changing character of the caseload during the demonstration phase is reflected in this chart:

Children Who Have Received Services
By Category of Risk

	Total	I Established Risk	II Biologic Risk	III Environmental Risk
Year I	19	7	5	7
Year II	31	8	8	5
Year III	37	4	4	19
Total	87			

In the chart above we group children who were accepted through June, 1979 whereas in the next chart we divide the caseload in subgroups through March, 1979. In subsequent sections of this report, we have compared the groups in terms of selected demographic characteristics and also in terms of their utilization of NSSI services.

In retrospect, it must be said that we have real reservations about the usefulness of these particular groupings. While they categorize information about the children that was available to us at our initial contact, the groupings fail to convey what we learned about the families which often influenced the kind of program we developed. Our reservations about the utility of the groups reflects both the complexity of developing a home-based program for low-income, high risk infants and also the characteristics of our model. These categories might be sufficient if the children were attending

Grouping and Sub-groups of Children Enrolled 9/76-3/79

	Sub-group	No. of children in group	Definition
I: Established Risk	B	7	Congenital anomalies: includes severe hemangioma, metatarsus abductus, severe congenital heart problems, multiple congenital anomalies.
	D	1	Visually impaired: undiagnosed origin.
	G	4	Diagnosed CP.
	J	2	Genetic syndromes: Downs' syndrome, Hurler's syndrome.
	K	4	Brain dysfunction: blind/microcephalic, brain damage, congenital brain dysfunction.
	Total	18	
	%	24.7%	
II: Biologic Risk	A	8	Abnormal muscle tone: hypotonicity, spasticity, tight hips, tight femoral abductus, scoliosis.
	C	4	Prematurity and related complications: 26-34 weeks, occipital encephalitis, hyaline membrane.
	E	3	At risk secondary to neonatal complications: apnea, post-viral, high risk.
	F	4	Failure to thrive (FTT).
	H	1	Motor delay/undetermined origin: neurological problem.
	N	4	Seizure disorders: infantile seizures.
	Total	25	
	%	33%	
III: Environmental Risk	I	10*	Language delay: referred as language delay, confirmed by an assessment, non-organic origin.
	M	11**	Abuse and neglect: referring agent suspects a/n, all had 51a's filed, referred as preventive measure, help in defining what other services family may need.
	O	6	Parenting/support: referring agent questions parents' caretaking ability, 51a may be filed on sibling but not client child, less chronic family dysfunction and family support.
	P	4	Parenting/focus on toddler negativism: parent overwhelmed by toddler behavior.
	Q	2	Medical coordination for translation: response to referral source unable to provide translation service to medical facility.
	Total	33	
	%	43%	

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* Includes 6 long-term, 5 short-term.

** Includes 8 long-term, 2 short-term.

a center-based program. Whether a center-based program would be appropriate is a different matter. A different set of groups that related more closely to NSSI's actual programming and that would have been useful in future planning would have categorized families according to the needs the adults presented. In other words, in NSSI the program is differentiated and individualized almost as much according to the perceived needs of the adults, specifically the mother, as according to the child's presenting diagnoses. Useful categories might differentiate families according to levels of organization, according to capacity to cope with stress, according to the degree to which the parents' needs appear to be in conflict with the child's (assessed perhaps by whether the referral source mentioned abuse and neglect) and according to the predictability of the mother's behavior. Clearly, it is more difficult to even begin to assess needs if a family is disorganized, in conflict, and if the mother appears emotionally unstable and has a previous psychiatric history.

Although NSSI children's age at referral decreased between 12/76 and 6/79, the average age at referral, 12.7 months, is higher than we had anticipated. Presumably, referring agents defer calling NSSI because they are not sure if there is a problem, because they think the problem will get better without intervention, or because they do not know how NSSI works. We assume that when we began to accept mother-child pairs who were at risk of maladaptive interaction, referral sources felt less constrained to specify the etiology of the problem they were concerned about. Health providers especially may assume that referral to an early intervention program constitutes labelling of a deficit which they are reluctant to do themselves and which they may be extremely reluctant to discuss with a parent. Clearly, all early intervention programs aim to prevent secondary handicaps as well as to remediate primary ones; NSSI extended the preventive focus further by accepting children whose parents were delayed or emotionally unavailable. In the process, we became aware that if the child's delay is of unknown etiology and if the child's need is not absolutely clear-cut, referrals to early intervention programs depend as much on the provider's assessment of the parent's functioning as on their assessment of the child. What we have observed is that when providers feel unable to meet adult clients' apparent needs because of time, style, or institutional setting, they may want to refer them. If the provider is concerned about his relationship with the client, she may also be dissatisfied. Sometimes providers seem so impressed with the inappropriateness of a caretaker that they may overlook unusual behavior in an infant. It has been fascinating to follow a small group of client children who were referred because their mothers needed "support" or "parenting instruction" and who turned out, after they had received services from NSSI, to have identifiable risks. Presumably these had not been identified because of the child's age, and because of infrequent contact with the referral source, but it is also tempting to speculate that, having identified the risk as intrinsic to the parent, the provider was especially reluctant to alter his diagnosis and to identify the child as having a problem.

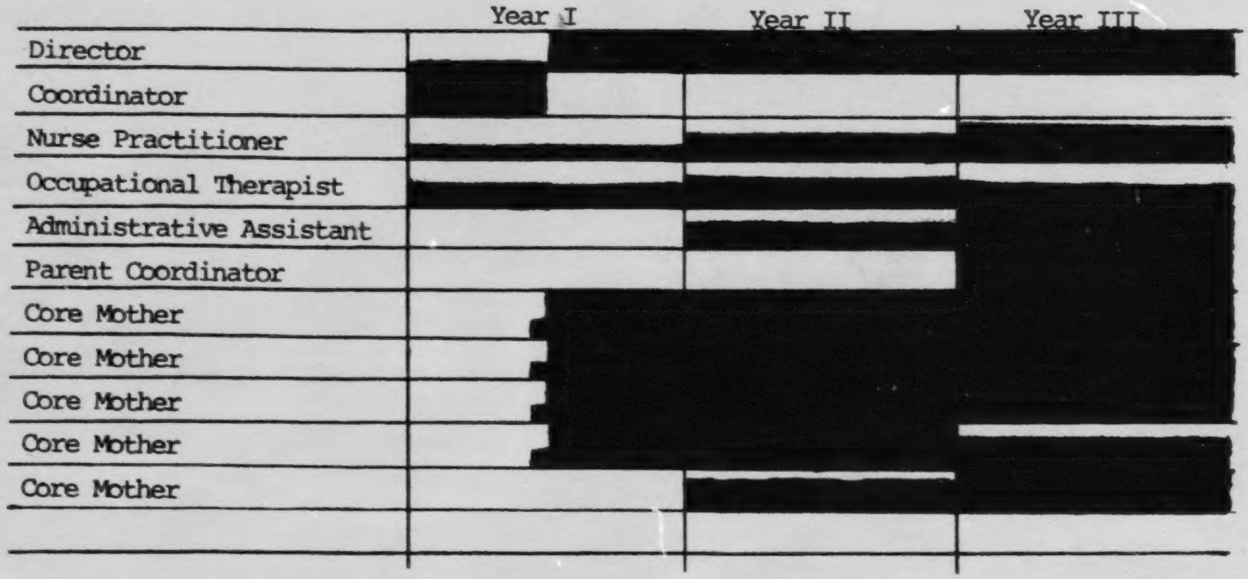
Dividing our caseload into the three categories described above, we find that the children in Category III (environmental risk) are older (average 18.7 months) at referral than those in Category I (established risk) whose average is a little under a year and more than twice as old as those in Category II (biologic risk) whose average age at referral is 6.76 months. It is interesting to note that the children in Category III whom we would assume to be at the peak of toddler negativism have, on the average, the youngest mothers (23 years). Mothers' age for I and II are 25 and 27 years.

III. NSSI Staff

A. Changes in Staffing Pattern

The chart below illustrates how NSSI staffing patterns changed during the three years of federal funding.

NSSI Staffing Patterns 1976-79



In the original proposal, full-time staff consisted of four Core Mothers and one coordinator who was responsible for recruiting and assessing clients and complying with federal reporting requirements in addition to hiring and training Core Mothers. Although a substantial portion of the personnel budget had been allocated for clinical consultation, NSSI's early efforts would have been assisted by clinical staff who were regularly available, who had full access to client records, and who were supportive of the program model. Initial lack of administrative support staff meant that neither data collection nor financial record systems were well established by the end of the first year.

Major reorganization began in the middle of the first year when the quarter-time Director was terminated by the agency; the coordinator assumed her role and began working with the pediatric nurse practitioner and the occupational therapist as a supervisory team with joint administrative and clinical responsibilities, even though both the therapist and the nurse worked part time. Hiring part-time staff sometimes means that scheduling is difficult, and that working relationships take longer to develop but for a small project it offers a cost-effective alternative to using consultants, with the additional benefit of continuing commitment.

At the end of the first year a two-thirds time administrative assistant was hired and the system for collecting clients' records and developing their Individual Program Plans was completed. The administrative assistant position became full-time at the end of the second year, so that data for the final report could be collected and proposals for continuation of the project's services could be completed. At the end of the second year, when CETA funds became available, we were able to hire a full-time parent coordinator who worked with administrative staff and Core Mothers and client families.

The need to increase the time the nurse practitioner and the occupational therapist worked at NSSI was not anticipated in the original application and reflects both the complexity of the clinical work and also the number of administrative decisions that characterize a new program. The continuity of the administrative team through NSSI's early years has facilitated this process. Clinical responsibilities which are shared by the nurse, the occupational therapist and the educator include assessing client children, acting as case managers for particular client families, and supervising Core Mothers. The shared administrative responsibilities include outreach to potential referral sources, dissemination of information about the NSSI model, allocation of cases to individual Core Mothers and decisions about changes in the design of the service delivery system.

All of the staff are white women, and except for the administrative assistant, they are all mothers.

From the beginning, it was assumed that Core Mothers would be parents; however, having administrative staff who are also mothers has been an unanticipated asset. Maternity increases supervisory staff credibility with NSSI clients and with Core Mothers, providing some common experiences for staff training and for supervision. In addition, we may reassure each other that we are not neglecting our own children at the expense of our NSSI clients. Except for the occupational therapist, all staff live in communities served by NSSI. Educational backgrounds vary from completion of 11th grade to Master's level--

seven of the women who worked as Core Mothers have completed high school, while the remaining staff have completed college.

Both the Director, who is an Early Childhood Educator, and the Nurse Practitioner had worked with the Headstart program in Somerville before joining NSSI, while the Occupational Therapist had worked with both handicapped and able-bodied children under three in both home visiting and center-based programs.

B. Hiring Core Mothers

Hiring the right people to be Core Mothers in NSSI requires experience, common sense, luck and time. Hiring carefully is crucial since, although we know that pre-service training helps candidates acquire skills that are useful in their work with families, we also know that much of a Core Mother's impact depends on personal qualities that we hope to assess during the hiring process and that we are unlikely to be able to change.

During the demonstration phase the structure of our interviews changed from two separate meetings--one in the office and one in the candidate's home--to a single, lengthy office interview and, finally, to two office interviews. Most recently, veteran Core Mothers have participated in the final interviews because their assessments are acute and also because applicants are curious to meet them. NSSI's director has been accompanied at all final interviews by another administrative staff member, most often the nurse practitioner.

Core Mother applicants have sometimes come to NSSI through newspaper ads but more often after a personal recommendation by a teacher, co-worker, supervisor or friend who knew both the program and the potential applicant. We have interviewed former clients, employees in center-based child-care programs, homemakers, day care mothers, waitresses, and factory workers as well as women who were not working outside of their home.

Five of the nine Core Mothers we have hired have raised children with identified handicaps (mental retardation, aphasia, cleft lip and palate, severe dyslexia, emotional disturbance); two others have children with minor learning disabilities requiring extra help in school. Two women have had extensive experience with infants--as a day care mother and as a foster mother. The original proposal had stated that "successfully raising a handicapped child" was a prerequisite for Core Mothers. We were not able to meet this requirement and we have become less convinced of its merit. The assumption that raising a handicapped child is an essential common experience from which one gains particular sensitivities and skills overlooks the enormous variety of parents, children and handicapping conditions. Surely, there are other routes to the acquisition of the relevant personal qualities. Some parents of handicapped children whom we interviewed said, after they learned more about the job, that they were not interested--they wanted work to be diverting rather than a continual reminder of a painful part of their life. On the other hand, the mothers of handicapped children whom we did hire talk about how their own experience motivates them when they have clients who are resistant or frankly negative.

In the interview we hope to uncover strong values about child-rearing and we want to learn from the candidate what personal and occupational experience she has had that might be relevant. After describing the program and some of the typical events in a Core Mother's day, the interviewers ask about the candidate's own family (what's been hardest for you about being a mother?) as well as her experience in her family of origin. In the course of their work at NSSI, Core Mothers often reflect on their own childhood. Our impression is that when their reflections are predominantly conflicted and unhappy, their work in NSSI is more difficult. Interviewers are interested in whether someone who wants to help others as a Core Mother has experienced situations where she has been helped, because we feel that it is a predictor of better work. One Core Mother told us as she resigned that she had never been helped by anyone outside her family and was always uncomfortable representing a helping agency. How reflective and self-aware does a candidate appear? Is she able to describe how she learns? Has she tried to learn something new recently?

Interviewers always want to learn if a Core Mother applicant has had experience with young children who have special needs and with children who have been abused or neglected. NSSI staff have relied on a combination of open-ended questions and hypothetical situations to elicit a candidate's assumptions. (What would you say to a mother if you were concerned that her child's diaper rash had been seriously neglected? and How do you think a mother would feel after a 51a was filed?) Finally interviewers want to learn how candidates feel about supporting independence in both able-bodied and handicapped children; for instance, they may raise questions about feeding, toilet training, and discipline in order to learn if a candidate uses a developmental framework and how much she emphasizes individual differences.

At the second meeting, we return to the aspects of the job that are particularly difficult, such as working alone, confronting the unexpected, and having to build relationships with women who are not "good mothers." At the end of a year and a half with NSSI, the four initial Core Mothers all described working with mothers as the part of their job they found hardest. They had applied for the job because they had enjoyed their children and because they felt comfortable as mothers. The inservice training focused on child development. They were particularly excited about children's progress. However, in their first year on the job, they had spent more time talking with NSSI parents than interacting independently with NSSI children. Commitment to building a relationship with program mothers seems key to job satisfaction in NSSI; indeed, Core Mothers who over-identified with client children sometimes felt angry, depressed and frustrated by client mothers when they were not appropriately nurturing. On the other hand, we have not hired candidates who indicated exclusive interest in mothers and who suggested that the child's development was incidental.

A series of discussion interviews may take ten to fifteen person-hours but we have learned that careful hiring saves time later on. Not surprisingly, it has also become easier to identify qualified candidates with experience. From the women we hired initially we have learned not only who is suitable for the job but also what the job involves.

IV. Staff Training

NSSI's staff training began with participation in courses, seminars and other presentations normally associated with inservice education but rapidly grew to encompass a broader range of experiences. As we became aware that staff had individual needs depending on prior experience, their own learning style, and their current caseload, we tried to become more flexible about what constituted an appropriate staff development activity. Planned inservice training continued throughout the three project years. Many inservice sessions were carried out by outside resource persons who had been identified by the administrative staff around program needs. NSSI's training sometimes reflected what was locally available. If it was free of charge, the likelihood of our participation increased. A typical example was an introductory course in identifying and referring alcoholics offered by the local alcoholism rehabilitation program. It was accredited by a neighboring community college. There was no fee. It provided a vehicle for NSSI to establish a referral relationship with another agency, and it focused on a problem found in the NSSI population. In what follows we return repeatedly to several characteristics that seem especially important in describing NSSI's staff training: whether it was planned in advance, whether it was organized just for NSSI staff, how many sessions it involved, whether it was ongoing or time limited and where it took place. In addition, we have tried to describe the informal interactions that allow all staff to be both teachers and learners. Finally we have suggested questions about training that remain perplexing and that we are currently trying to address.

A. Planned Inservice Training: A Brief History, 1976-79

A brief history of inservice training offered in NSSI follows, divided into three program years. Each year covers September to June, because these months represent both the program's period of most active service, and the time when Boston-area universities and teaching hospitals made more offerings available. During the summer months, the administrative staff took advantage of reduced service demands to evaluate and plan the program. Each new year tended to repeat this pattern. Appendix H includes a catalogue of all training activities engaged in by NSSI staff between July, 1976 and June, 1979.

Inservice during the first program year (September 1976 to June, 1977) was basic and general, addressing the inexperience of the majority of the staff with early development and early intervention. For Core Mothers it began with an introduction, "Infant and Toddler Growth and Development," taught by the administrative staff. The first year inservice primarily focused on children, starting with normal development and later covering special needs.[1]

NSSI administrative staff sought in-service training about special needs children and about program development and infant assessment. The director and nurse practitioner, for instance, both participated in a short practicum on administering the Bayley Scale of Infant Development.

During the second year (September, 1977 to June, 1978), most Core Mother training was given by persons outside of the NSSI staff. In addition, as opposed to year one, when their inservice for Core Mothers was defined by administrative staff, they began making more choices about what they wanted to learn, either individually or as a group. For instance, two Core Mothers elected to participate in a five-session course presented by another local early intervention project. Another Core Mother requested an independent consultation with the trainer of the "Death and Dying" seminar which all Core Mothers had attended the previous year, because she felt she needed additional help with a family whose child had a poor prognosis.

The administrative staff largely continued to elect training in program development and special needs areas. Interestingly, however they participated in several seminars dealing with parenting and family dynamics, a clear expansion from the earlier focus on children and a reflection of the program's beginning shift from exclusive emphasis on the child to a focus on the parent or the parent-child interaction.

The third and final year (September, 1978 to June, 1979) presented NSSI with a new set of inservice needs. Three Core Mothers were hired to join the two who already had two years of work experience in the program.

Those newly-hired received what had by that time become a basic inservice package: normal growth and development, homevisiting, written communication skills, and instruction in writing interventions. In addition, they observed a series of home visits made by experienced Core Mothers.

Experienced Core Mothers elected a variety of outside training and participated in inservice sessions planned for the entire staff, though no "advanced level" package was developed for them.

Inservice relying on outside experts who had come to the attention of NSSI administrative staff became more common in this third year. For example, TADS agreed to support Dr. Rose Bromwich's trip from Los Angeles and she spent two days describing and demonstrating the use of her "Parent Behavior Progression." Dr. Daniel Rosen, who has both clinical and research experience with failure-to-thrive children at Children's Hospital in Boston, discussed the issue and responded to questions in a one-morning session.

In addition, a week-long orientation for the entire staff to Project Hope, the adjunct program, aimed at teenaged mothers, was conducted primarily by outside speakers who were local experts. In summary, the format was new and the content focused on the parent or on the interaction between the parent and the child.

The program evaluation provided another important inservice experience. For administrative staff, it involved exhaustive discussion about every facet of the program's development, giving them valuable insights and leading to further improvements. For Core Mothers, it was useful not only for concrete feedback on their home visits but also for recognizing the importance that was placed on that role and the experience of conceptualizing it.

In the third year, when NSSI administrative staff discussed training with the evaluator, they realized that the major portion of ongoing inservice training was actually taken care of on an informal basis.

It seemed appropriate to characterize as inservice education the spontaneous, client-oriented problem-solving discussions which occurred naturally, and on a daily basis, among the project staff. In addition, the NSSI library became an increasingly useful resource for individual education. Including standard medical references as well as child development texts and infant curriculum outlines, the library's growth reflected new interests and needs. Some readings were consciously circulated among staff, others suggested or simply made available for use.

B. Staff Attitudes Toward Learning and their Influence on Inservice

The two primary groups making up the NSSI staff, administrators and Core Mothers, are different with respect to education, class background, and life experience. Influenced by these, they had different responses to learning, which were illuminated most clearly in reactions to inservice training sessions; that is, decisions about what to expect from it and what form and content were most useful. Understanding these differences is extremely valuable in planning for staff development.

While there were minor individual differences within groups as well, it is the difference between groups we will discuss here.

As mentioned in Section III of this report, the administrative staff was college-educated, and possessed well-developed reading and writing skills. They tended to integrate academic pursuit into their lives and nearly all had had recent graduate school experience.

On the other hand, Core Mothers had not gone beyond the twelfth grade. They had been raising families and had not had formal educational experience for years. However, they were active learners and so any training which might presume to teach them routine child care was considered gratuitous. They already knew how to bathe a baby or take a toddler's temperature. We have identified three general characteristics of Core Mothers as learners.

1. Core Mothers expected a simple formula for "How to be a good Core Mother.'
2. Core Mothers found little use for academic credentials.
3. Core Mothers were action-oriented.

1. Core Mothers expected inservice to be job training. Their assumption about knowledge seemed to be that it was complete, and that learning was a simple task of taking a finished body of information and directly applying it to work. They expected concrete, skill-oriented teaching from which they would learn the "right" way to be a "good Core Mother.'

However, the role of the Core Mother was not defined as it was virtually unprecedented. Administration was flooded with requests for "Just-tell-me-what-to-do." Training for comparable professionals' roles although incompletely defined, tended to be process rather than skill-oriented. During NSSI's first year this was not appropriate for Core Mothers, although they had to be reminded often that no one, including the administrative staff, had a simple formula. Later they talked about their initial anxiety and how disturbed they had been by the notion that there were no simple steps to follow. During the program's third year, a Core Mother asked the Director, "I just want to know one thing. Were you (administrative staff) as scared in the beginning as we (Core Mothers) were?"

Administrative staff, on the other hand, were somewhat more relaxed about job definition. Being more familiar with the incompleteness of knowledge, they had less impatience with partial information and a process of synthesis over time. They were also somewhat more comfortable with the idea that the project was developing a model, and, therefore, had no pre-existing blueprint. They primarily expected inservice to provide them with new ideas and information they could use for program planning and clinical application.

2. Core Mothers and administrative staff also looked differently at credentialling: accruing academic credits for inservice training. Administrators were eager to collect credits because they considered credentials valuable additions to their resumes and useful for their careers, of which working at NSSI was only a part. Core Mothers saw their work in the program as a job which had unclear value for future employment, and therefore the notion of "credentials" had dubious value.

During the spring of the third year, for example, the Director and Nurse Practitioner spent two afternoons a week at the Cambridge Hospital newborn nursery achieving reliability on the Brazelton Neonatal Behavioral Assessment Scale. This was a project they undertook not only because of the techniques it offered for the assessment of very young infants but also because it was an attractive addition to their resumés.

Core Mothers, on the other hand, did not always apply for the credits which were offered for a number of inservice courses through the Open College Program of a local community college. Credits could be applied toward an A.A. degree; however, the uncertain value of that credential and the fact that course completion was seen as a verification of personal accomplishment made the credits not worth their purchase cost.

3. Over a period of time, Core Mothers clarified their need for inservice to be skill-oriented in content and succinct and action-oriented in form. Their definition of work was action: making home visits, talking with mothers, working with children. They responded least favorably to lengthy theoretical presentations. They had difficulty

identifying sitting and listening as work or relating it to their action-oriented point of reference.

Though theoretically aware of these training needs from the beginning, the administrative staff persisted in designing inservice with which Core Mothers were dissatisfied. Core Mothers criticized whole day sessions for being too long, and didactic presentations as too "lectury" and abstract.

In response to this persistent criticism, formal inservice was gradually offered in sessions lasting no longer than two hours, with more emphasis on Core Mother participation. Core Mothers continued to be notified of day-long lecture conferences and encouraged to attend but on site that format disappeared from the program's inservice planning.

Over time, the administrative staff did develop a sense of what Core Mother training entailed, and while administrators found inservice that was useful to themselves as well, they were often disappointed.

Because most of the staff did not have a strong background with children under three, an important task was to uncover information about early intervention programs. Initially we believed that because many such programs existed, extensive knowledge existed, and NSSI simply needed to locate and then apply this extensive knowledge. To accomplish this goal, NSSI staff exhaustively solicited materials from other programs even remotely resembling its own. We visited sites of similar programs and asked those programs to visit our office. We religiously attended any conference whose content touched even a single aspect of our own work. Through both TADS and local contacts, we actively sought out other professionals for the purpose of discussing early intervention and issues related to it. We judge all of this to have contributed a modest amount to our program, and certainly a great deal less than the amount of effort NSSI devoted to these activities.

In addition, NSSI was attempting to develop a unique model, with a transdisciplinary approach. Also it wished to acknowledge that a paraprofessional possessed the integrity to go beyond a simple carrying out of prescriptions devised by professional staff. In other words, the issues which were presented to NSSI by its population and the resulting questions by the program were substantially unprecedented in past programs, and/or practice, and existing programs were of a sufficiently different nature that they too offered unsatisfactory answers.

For example, the Nurse Practitioner wanted information about the effect of various chronic medical conditions on a child's developmental progress, such as how a severe, congenital cardiac anomaly might affect the physical capacities of a two year old; or, in planning a cognitive intervention, what was a realistic expectation for a nine month old who had broncho-pulmonary displasia secondary to a premature birth? The available literature on these conditions described life-saving techniques for the high-risk neonate in rich detail but did not predict or follow the progress of the child after hospitalization when he or she is living at home. Clinical information was also too sparse for our purposes. Most pediatricians are aware of development in only the most general terms. For a few child progress was defined as weight gain and being illness-free. It was a rare conference in which a health care provider integrated medical and developmental information.

C. Informal Inservice Training

Several factors, both planned and unplanned, were responsible for the development of informal inservice within NSSI. The project staff was composed entirely of women. Secondly, it never exceeded ten in number and therefore there was a possibility for high interaction among all staff. Thirdly, the physical layout of the office lent itself to impromptu staff discussion. Early space limitations forced the program into one room with a single large table rather than individual desks for its primary work area. As this arrangement proved advantageous, it was continued even when additional space became available.

The program's responsiveness to Core Mothers' questions and their difficulties with formal training experiences led to ongoing informal exchange of information which later was defined as training. To give the reader a flavor of this kind of interaction, we will describe a typical office situation.

The NSSI office is a lively place, with several conversations going on simultaneously. One Core Mother, for example, can be planning with a more-experienced Core Mother how to best present an intervention to a client. At the same time, a third Core Mother is talking to the Case Manager about her observations of a home visit. The Occupational Therapist may be asking another Core Mother how well the toy she suggested the previous week for a child had been received in the home.

In the beginning of the project, these interchanges were seen as a chance for Core Mothers to "blow off steam" after home visits, and thereby reduce their own anxiety. They were gossipy. The administrative staff viewed them as an irritation and a deterrent to constructive program work. In an attempt to limit the time they consumed, a weekly meeting was instituted to be used by Core Mothers to relate information about families, exchange ideas about their work with families, and problem-solve difficult situations. The meetings were a success, occurred regularly, and Core Mothers looked forward to them. However, their need to talk immediately following home visits persisted and occurred as it always had. Administration realized that these sorts of discussions could not and, finally, should not be contained.

Over time, the way in which families were discussed changed. Increasingly, this informal discussion became more focused on observations and medical or case management questions. As Core Mothers gained self-confidence, they were less anxious about their home visiting, and simultaneously, the administrative staff gained clarity about their responsibilities and scheduled two more structured interactions with Core Mothers: case management and supervision. Designed to help Core Mothers to direct and organize some of their information to specific persons at specific times they hoped to reduce the phenomenon of talking about problems to whomever might be in the office to listen. By the third project year, however, administrators had recognized that spontaneous exchange was, in fact, a necessary and valuable form of training; they tried to use it to channel and respond to Core Mother needs.

Sometimes, planned inservice training grew out of informal exchanges. For instance the presentation about "Failure to Thrive" children was the result of many spontaneous discussions and questions about client children who were labeled as such.

Informal inservice also encouraged a two-way flow of teacher-learner roles which the program considered desirable. At times administrative staff were teachers, and at other times Core Mothers were. Once, for instance, when a client called to get help with her child's sleeping problem and her Core Mother was out of the office, the Nurse Practitioner took the call. After hearing a description of the problem, the nurse asked several Core Mothers who were in the office to suggest some solutions to her, from which she made some suggestions to the mother. "Though I knew what the literature would suggest," she later recalled, 'I hadn't had this problem with my own son, and I wanted to get ideas from more experienced mothers."

As with all new programs whose staffs are encouraged to be self-reflective, NSSI was able to ask many more questions than it ultimately answered. Consequently, several issues of staff development remained unsolved after the third year.

Four questions are outlined here because they provide insights into NSSI but also may prove valuable for other new or similar programs.

1. What role does client advocacy play in a program?

2. What supports are necessary in high-stress programs?

3. Can highly trained Core Mothers retain their closeness to families?

4. Should staff be encouraged to seek training outside NSSI?

1. The importance of Core Mothers' client advocacy role became increasingly clear during NSSI's operation. As described in Section V (parts 3, 4, 5), Core Mothers spend

significant amounts of time accompanying clients to medical appointments, or taking them to the welfare or leased housing offices. In each case, the Core Mother's goal was to assess the client's needs, help her to meet them, and ultimately to help her meet them independently.

Initially, NSSI grossly underestimated the complexity of client advocacy and believed it to be a "natural" skill of Core Mothers. No training in advocacy was offered, and we have only recognized the necessity for it in retrospect. During the final year, administrative staff did address advocacy, but it occurred inadvertantly. Initially, some Core Mothers took a course "Working with Difficult Families" about which they chronically complained in the NSSI office. Project administrators encouraged them to voice their dissatisfaction, but they declined to do so and unhappily suffered through the course to its completion. A few months later, a home visiting course was offered by a local training agency, and three Core Mothers elected to take it. In order to fend off the possibility that it also would not address their needs, one administrative person also enrolled. Consciously, she decided her role would be to advocate for Core Mothers in much the same ways they were expected to advocate for their clients. Administrative staff believed that Core Mothers would become better client advocates as they experienced its benefits themselves. Administration was never explicit about modeling advocacy techniques in this situation, nor were the similarities between this and Core Mother advocacy ever discussed. As a result, we are unsure whether this technique is effective. However, we believe advocacy training is a strong need in programs like ours and remains one for us.

2. Although work in NSSI is interesting and dynamic, it is often depressing and emotionally draining as well. Any work situation, to be productive, obviously requires staff members to maintain a fairly constant level of interest and excitement about their jobs. Experience proved that when a staff members ceased to be stimulated by her work she could quickly spiral into a "burnout" state which might lead her to consider leaving the program. Administrative staff thought Inservice could serve a nurturant, motivating function and could offer a respite from demanding work. They tried to use it to excite Core Mothers about their client families, to keep them growing and learning, experimenting and evaluating, looking at families in new ways and using different approaches with them.

The question that arose was whether, in fact, Core Mothers shared that view of its uses or saw it as an additional burden that required special scheduling.

3. In struggling with the question of whether NSSI's basic inservice training for Core Mothers was sufficient or whether a more advanced component should also be designed, we wonder whether the acquisition of more sophisticated skills might distance them from clients. Administrators' own view of their advanced educational training was that the "professionalization" they acquired sometimes meant forfeiting their own personality in order to relate to clients in a prescribed, "objective" way. It involved learning a new "therapeutic" language to use with clients.

NSSI's staff were wary of "professionalized" relationships. Many of our clients had been unable to relate to or be helped by professionals in the past. We assumed that one of the reasons they developed a realtionship with a Core Mother, which they might experience as therapeutic, was that the Core Mother was seen as a peer. Clients knew that individual Core Mothers each had distinct personalities and styles, and were seen as peers.

The remaining question, however, is whether it is possible to separate skill training from a process of "professionalization." Can Core Mothers become more competent in the areas of child growth and development, family dynamics, and home visiting skills, for instance, and still retain the strengths of their peer relationships? Or will the process of acquiring more knowledge automatically produce "professional" Core Mothers who are less effective in their work with families?

4. A final puzzlement revolved around the usefulness of inservice offered outside of the program. Initially most Core Mother training was done by the administrative staff, who felt that they knew best what Core Mothers needed to learn and could therefore develop a more effective learning experience. In part this happened because administrators were not well acquainted with other training resources. As relevant outside courses were identified, Core Mothers took advantage of ones that appeared to be useful to their jobs, but often these did not focus on either what they wanted or needed. There were benefits, however; these experiences gave Core Mothers an exposure to other social service personnel and an opportunity to present and compare themselves to them. They also became familiar with a variety of teaching methods.

Whether these benefits justified the investment of time and money they involved is an open question.

V. NSSI Services

There are many sorts of services that have been offered by NSSI to families since children were first accepted in the program in December, 1976. We will describe these followed by some data about their utilization.

NSSI families do not receive the same services, equal amounts of service from week to week, or remain active in the program for the same length of time.

All families do receive some combination of the following program elements:

Initial Assessment and Individual Program

Home Visits

Transportation to and Support at Medical Appointments

Respite

Parent Group Activities

A. Initial Assessment and Individual Program Plans

a) Two NSSI administrative staff make the first home visit together. During this visit they describe program services and complete a short family history. One of this administrative team evaluates the target child by administering the Bayley Scale of Infant Development (BSID) and the Sewell Early Education Development (SEED) Inventory.

The BSID is a standardized, widely used infant assessment instrument which yields a developmental score in both mental and motor areas. The mental scale has twice as many items as the motor scale and although we intend to administer both fully we do not always bring the stairs and walking board that are necessary for the motor test after one year. Depending on the age and cooperation of the child, test administration takes between twenty and forty-five minutes and requires a suitcase-full of standardized material including blocks, cups, bells, and rattles. Parents usually watch quietly, apparently fascinated by the materials and by the visitor's efforts to engage their children. Basically we used this test because it is the most widely used infant test.

We use the SEED in addition to the BSID because it has more items which seem to better assess the child's functional behavior. The format divides a child's performance into four areas: motor, adaptive, social and language. This allows us to understand how a child functions in areas which seem more usual in his natural life at home, such as playing patty cake, responding to music and climbing into adult-sized chairs.

We had hoped to use the BSID as a measure of program effectiveness. We have had two different sorts of problems with the Bayley. First, our data did not have the benefit of inter-tester reliability; sometimes, a child was tested by different examiners while some children only experienced one tester; the time between successive administrations of the instrument varied as much as a month across children and were scheduled according to the child's age at entry into NSSI. As a result, we have a group of non-comparable scores because they are at different ages.

Second, there are problems with the Bayley itself. Since it was standardized on a normal population, it over-emphasizes motor performance, and presumes that early development is continuous. Its results are vulnerable to the mood and psychological state of the infant. For these reasons, we have found Bayley results useful for impressions about developmental changes and for decisions about the goals of any fine motor interventions, but we have not found them useful as a way to assess program impact on child progress.

The most consistent and complete information is available on the mental scores of the long term cases. We have included this information in Appendix F along with the motor scores when they were available. In an attempt to identify some gross patterns across our children's Bayley scores, we selected a few sub-groups that are representative of the NSSI target population, as to attempt a comprehensive review of the entire child population was impossible for the reasons cited previously. Three groups were chosen for this purpose. They are: A (abnormal muscle tone), B (congenital anomalies), and F (failure to thrive). See Appendix F .

Both groups A and B show a slight trend to elevated scores after they participate in the program for four to eight months. It is difficult to interpret group F's scores as they show no discernable pattern. Possibly this reflects the diversity of children with a failure to thrive, or the fact that they were older and more difficult to test.

The data from both the Bayley and the SEED is used to set the child's goal in the individual program plan (IPP), revised every four months. During the period of federal funding we simplified the process of developing the IPP. For the first year and a half, following an assessment all three administrators met with the Core Mother who was assigned to the family to discuss appropriate developmental and non-developmental goals. Together we drafted a description of the child's present functioning and a series of developmental objectives, which the

Core Mother shared with the parent. At first these covered a three month period but we decided that four month intervals were more practical. We invited parents to amend these but few responded.

By the end of the second year, NSSI's caseload had grown and it seemed important to clarify administrative responsibility for individual clients. Also administrative time needed to be used more efficiently. The Director, the Nurse Practitioner and the Occupational Therapist divided the caseload and each became "case manager" for some portion of it, assessing children, developing the IPP with the Core Mother, and reviewing her weekly home visits with the family.

By the third year NSSI wanted to stress the involvement of parents in the IPP. As a result, the case manager and Core Mother began writing IPPs with client parents in their homes or in the NSSI office. We felt if parents participated in setting objectives for themselves and their children, perhaps they would be more interested in achieving them. Although the rates at which children achieve objectives have not been compared, the participation of parents in the plans for their children seems to result in objectives which are more individualized and concrete. Examples of IPPs are included in Appendix B .

How to review the attainment of objectives in each IPP was not clearly established in the early stages of the program, although they *were* reviewed at the time of re-evaluation. Consequently, there is insufficient and inconsistent information on the achievement of objectives. It is possible, however, to examine the *kind* of objectives set for individuals and subgroups, although this reflects as well the staff's ability and bias in setting objectives. We find that, on the average, each IPP includes sixteen objectives, two-thirds of which are developmental tasks for the child and one-third of which are objectives for the parent and the NSSI worker. The number of objectives on IPPs has ranged from six to forty-two and how we develop one depends on the amount and the clarity of the information we have about a family. The case study in the Appendix suggests several different roles that an IPP may play in NSSI's relationship with a family.

B. Home Visits

When a family is accepted by NSSI, it receives regular home visits; most often scheduled on a weekly basis, usually lasting between an hour and an hour and a half. The most variation occurs in the number of visits per week which can range from twice a week to once every two weeks.

The Home Visit includes discussion of the child's development and the presentation of activities or what we called interventions. Usually written instructions were left with the mother to remind her of the activity after the home visit. Some time, however, during the home visit is frequently spent listening to mothers describe other concerns. Our understanding of the function of the interventions has changed over time. Initially we were influenced by what we thought was acceptable to BEH. We were eager to measure results, and confident about our intended and fairly exclusive focus on the child. Core Mothers thought of interventions as remedial activities and adapted them from published, behaviorally oriented infant curricula. Although Core Mothers were able to successfully present these activities to children, teaching parents to do so was more complicated. In our experience, unless the Core Mother demonstrated the interventions with enthusiasm and unless the client mother enjoyed the particular intervention, it would not be implemented regularly by the mother when she was alone. Adapting and developing any interventions consumed an enormous amount of staff time in the NSSI office. It appeared both more practical and effective to abandon these efforts and encourage Core Mothers to introduce activities whose main characteristic would be that mothers would find them fun to do, that mothers would do, and that therefore would encourage more interaction between mothers and their children. We thereby adapted our initial notion of what constituted a remedial program when we encouraged Core Mothers to change interventions by observing what the baby and the mother liked to do in order to plan for the next visit. Sometimes we tried to incorporate a recommendation from the consulting physical therapist. The Appendix C includes a selection of sample interventions compiled and annotated by NSSI's Occupational Therapist. Because of her experience and her professional training, she assumed most responsibility for helping home visitors develop interventions.

We thought it would be useful to include here an observation of a home visit which we cannot label "typical" as none can be described this way, but which will give the reader a flavor of this part of our program.

This particular home visit is to a woman we shall call Mrs. Mandeau. She has a husband who manages a branch of a chain food store. Her four children range in age from 15 months to 10 years. She has moved to a new apartment which is larger. She has been a client of Ruth Path's for nine months. During this time period the family has had several crises involving suspected child abuse, marital problems, the husband's job loss, chronic housing difficulties, and periodic concerns about the mother's health. Ruth Path has seen the mother and child on the average about once a week.

The observer has visited once before, near the beginning of the family's relationship with NSSI. This time, Mrs. Mandeau's front door must be unlocked by her. It is a sweltering summer day, but her house has a steady breeze. When she opens the door, we see that her neck is encased in a Thomas collar. She is a woman who is definitely overweight. She smiles at the observer, but begins to chirp at Ruth Path, holding her hands and fingers forward to show them to Ruth, who grabs a few fingers of Mrs. Mandeau's left hand in an impulsive, affectionate grasp. Ruth moves her forehead to rest on Mrs. Mandeau's looking into her eyes, mock-scolding her that she never wears the collar enough so that she cannot sufficiently reduce the swelling to her hands. Mrs. Mandeau responds very affectionately. We all go inside and she immediately gets her baby, Denny. Ruth prepares by sitting on the floor and lighting a cigarette. She talks to Mrs. Mandeau about her own impending move to New York state. Mrs. Mandeau says "I called your house at 9:30" but she is interrupted by the phone ringing. She answers "Can I call you later? Yeah, Ruth's here. What's the matter? What's the matter? Oh, he's always got a virus." She then turns the receiver away from her mouth, looks at Ruth and fires, "Lost a tooth in front. Will he get another one?" Ruth answers. When Mrs. Mandeau's call is over, Ruth makes one. Mrs. Mandeau begins to dramatically and humorously lecture Ruth about the equipment she brings from NSSI. "Don't leave nothing! I still can't find the shape thing you gave me. I found the box, but not the shape. I don't want to be responsible for things that aren't the kids." A child comes to the window. Mrs. Mandeau sees it out of the corner of her eye. She immediately barks "Chris! Go play!" "Is mail delivered today?" Ruth asks Mrs. Mandeau and the observer. Mrs. Mandeau answers immediately "Checks. Oh, I got that big check. Paid all the dental bills and there's $40 left. Supposed to be $100 in there." Ruth comments on the baby and Mrs. Mandeau responds "He won't let go of those blue ones" in reference to a toy Denny is playing with. Ruth now takes off her shoes and she and Mrs. Mandeau discuss glasses. "I still have trouble with that head doctor" Mrs. Mandeau complains.

Ruth: Gibson?

Mrs. M.: The baby's covered by medical. They're all covered by medical. I don't know why I keep gettin' these bills.

Ruth: (to Denny) Got your finger in the wrong end, love! Blue your favorite color? (Mrs.

Mandeau begins to move in to help Denny perform the stacking toy task better.) Leave it! I want to see if he'll do it!

Mrs. Mandeau observes her baby for a minute. "Want to do it myself, he said. Want to do it myself." she repeats in an imitation of a babyish voice. She praises Denny continuously as he works with the toy. The baby sneezes once, very softly "Bwess oo!" Mrs. Mandeau says solicitously. She then turns to Ruth again, who has mentioned her weekend. Mrs. Mandeau says "What did you do all weekend?" Ruth goes into an explanation of what her husband is doing to put their house into good condition for the new owner. "Oh, that's nice" replies Mrs. Mandeau. "You should see the holes the plumber made in my basement." Ruth turns to the observer and says, "Oh, you missed that" referring to something the baby has done. Mrs. Mandeau immediately explains that the baby had tried to bite off a ring on the stack toy when he could not get it off any other way. Ruth talks to the baby. "What you gonna do when I put this away and give you something else? You gonna be mad at me? Why don't you look at this?" The baby pats some pull toys Ruth has brought. Mrs. Mandeau laughs. "You gonna beat it, huh?" Ruth pulls the toy. The baby hangs on and pulls back. Ruth looks at the mother and says "You know that muscle weakness we used to talk about? Guess what? It's gone." The baby cries when the toy is taken away and then screams. "No" Mrs. Mandeau says in a soft solicitous voice and touches him on the nose with the tip of her index finger. She holds the baby's hand, walking him into the kitchen, where three adults are eating breakfast without talking. Ruth continues, "Usually, when kids start walking, it takes them a month to carry anything. He was doin' it in a week! He's got such great balance!" Ruth pushes a toy lawn mower full of bobbing toys toward the baby. "Everything goes in the mouth," Mrs. Mandeau comments, half disgustedly. The baby falls. "Get up!" Mrs. Mandeau barks immediately. "Come on. Get up! Don't be a lazy heifer." She tries to stop the baby from putting the knob at the end of the handle into his mouth. Ruth does not intervene in any way nor even appear to give this her full attention. After the baby lies on the floor for a while and Mrs. Mandeau has turned her attention away from him, Ruth pulls him gently by the ankles over to her. He squeals with pleasure. "Don't get rambunctious" comments Mrs. Mandeau. She holds her hand out to the baby. "Up?" she invites. The baby tries to push the toy and Mrs. Mandeau tries to encourage him. "You have to keep it in front of you" she says. He screeches softly but with objection at her intervention. "Don't tell me no!" she yells. He screeches again. "Take it to Ruth. Go on. Take it to Ruth," she says disgustedly.

This is only a partial account of the visit but contains elements which are common to many Core Mother family interactions.

The Core Mother frequently acts as a friend, an instructor, and a support especially to the primary caretaker--in almost all cases, the mother. Though the agenda is the baby and its developmental progress other aspects of the family's life, especially crises, can interfere with and divert, necessarily, the focus of the work. Core Mothers will frequently assist families with services which address other needs than those medical/developmental ones necessary to the child.

C. Hospital and Clinic Visits

Next to home visits, the service NSSI provides most frequently is transportation to and support at medical visits. In medical settings, our families may have regular contact with pediatric nurse practitioners, pediatricians, and with pediatric specialists such as pediatric neurologists and pediatric cardiologists and these are whom we mean by health care providers.

In addition, families see allied health personnel such as physical therapists, occupational therapists and nutritionists.

Health care providers, especially doctors, are important to most mothers of young children and especially important to mothers of children whose development appears unusual. Indeed, the doctors can either dismiss parental concern or keep it alive.

Parents in NSSI rely on the health providers' intervention when their child is sick and health providers are also the most respected non-family source of information about their child's early development. When the child's development is atypical, families often hope that the health provider will notice improvement and identify signs of progress

Analysis of audiotapes of selected NSSI home visits in the spring of 1978 confirmed that visits to medical facilities were routinely reviewed by Core Mothers and client parents.

In addition to getting information about their child's health and development, mothers may seek reassurance from the health care provider about their parenting practices. For first-time mothers, these visits are the most public exposure for their maternal practices. Most children under two have very limited institutional involvement; usually, they do not attend schools, churches, or recreational activities where they may be scrutinized by objective professionals. Medical institutions provide the first stage for parents to practice how they will represent themselves and their child's interests. In addition to what they may learn about their child, parents may be nervous about what they will expose about themselves. They often appreciate the companionship and support a Core Mother offers. Some parents need more support at initial appointments, while others who may have had unsatisfactory encounters with health providers need on-going support. Dissatisfaction may result from the information they received, from the provider's interactional style with them or their baby, or from some other source. For instance, a South American mother whose daughter's Cerebral Palsy required regular weekly physical therapy was unable to tell the therapist which exercises her daughter tolerated and which she refused. The therapist did not speak Spanish, the hospital did not provide a translator, and the mother did not always come to her appointments. With the assistance of a bilingual Core Mother, however, the child received therapy more regularly, the mother described problems she had with particular exercises and the therapist recommended adaptations.

When Core Mothers accompany parents at medical appointments, they usually provide transportation since few NSSI families own cars and public transportation is unpredictable. Before the visit, a Core Mother often helps her client recall the questions she wants to ask (will Helen's stomach always stick out? Why does the baby always look at my forehead, never at my eyes? Why does she still seem stiff even though I've been doing the exercises?) Since Core Mothers are usually present during the discussion of the examination, they have a second opportunity to remind the mother of the questions she hasn't asked.

Clearly NSSI's role varies according to the mother's needs and the child's medical involvement. If a child needs a comprehensive medical workup or becomes seriously illy, parents must communicate with many unfamiliar medical personnel, and must wait in order to arrange lab procedures, see the specialists, and hear their findings. Companionship and help with child care may relieve the waiting and the Core Mother's presence during the discussion following the examination means that she can help the mother remember what the provider said.

When Core Mothers accompany parents to clinics they describe NSSI's services to the nurses and doctors they meet. Just as the hospital or doctor's office provides parents with an opportunity to advocate for their child, so it provides Core Mothers with a more public setting than a home visit to demonstrate how NSSI works.

Core Mothers' outreach and demonstration may remind the provider of another family who would be an appropriate NSSI client. Although they may function more as participant-observers than as teachers when they accompany clients, Core Mothers' contact with medical providers may well be responsible for NSSI's substantial number of medical referrals. Locally, at the outpatient pediatric service sponsored by Somerville Hospital, Core Mothers are familiar with nurse practitioners and the pediatrician, and, in addition to a steady flow of referrals, their support has clearly influenced NSSI's successful search for continuation funding. In 1980-81, we will be working closely with the providers in this system to provide support to families which include children under three at risk of abuse or neglect.

D. Respite

During home visits Core Mothers may work alongside a client parent modelling a technique or demonstrating the use of a material with a child, or they may observe how the parent interacts with the child; during respite, the Core Mother replaces the client parent who is not present. Core Mothers can offer from one to three hours of respite care in their own homes, in their client's homes or outside in a park or a store.

Location depends on the age of the child, and the severity of his or her special needs, as well as the convenience of the Core Mother and the client parent. Clearly a Core Mother's schedule does not allow her to provide respite care for each of her clients weekly, so it is essential that new NSSI parents understand that respite is not regular child care. How much respite a family needs is discussed with the family each time an IPP is developed but respite is rarely available weekly.

NSSI staff are reluctant to have Core Mothers thought of as "mere babysitters" (although, as parents, they are all aware how valuable reliable, responsible childcare is) and Core Mothers hesitate to commit their weekly schedule completely in advance. Initially, some Core Mothers felt parents should justify their request for respite with a "worthwhile" activity; more recently, Core Mothers have agreed that parents can spend their time however they want and that the Core Mother should decide what *she* can learn about the child when the parent is away. Although initially somewhat resistant, Core Mothers are often impressed by what they can learn about a child and his environment when the parent is not home. They may appreciate for the first time how difficult a particular baby is to feed, or how irritable another child is when she wakes up. They also may be disturbed by what they learn; for instance, one Core Mother found an older sibling who was harnessed to her bed for a nap and another was told confidently by a sibling that "mommy never has time to do *those* exercises." On the other hand, since it is often easier to plan and structure time for one child than for a child and an adult, respite may also be relaxing for Core Mothers. When Core Mothers bring client children to their own homes, they usually enjoy encouraging their own children to play with them.

At the least, respite usually provides client children and their parents a comfortable separation experience since Core Mothers are familiar and trusted. This may be especially valuable to parents whose children are at risk medically and who may feel reluctant to let others share their responsibility. It may also offer the children additional cognitive and social stimulation when they are exposed to new situations and different styles of communication during their visits to Core Mothers' homes.

E. Social Service Coordination

When a family is referred to NSSI we ask whether other agencies are involved in order to avoid duplication and coordinate delivery of services. If the parent agrees, we contact the agency and describe what we plan for the parents and child. Other agencies may need several explanations of what a new program like NSSI can offer their client and most often NSSI initiates successive contacts.

Less than a quarter of families in NSSI require extensive social service coordination whereas we have contact with nearly all families' health providers. NSSI is less likely to refer a family to a new social service agency than to a different medical institution; more often, we work with the services that are in existence by responding to their questions about our role and by encouraging them to work toward some of our goals for the particular family. Most often we are in contact with agencies to express our concerns about deteriorating conditions to see if the other providers concur and to determine whether additional services (such as home-makers, transportation vouchers, or family day care) can and should be provided. Sometimes, it is necessary to call a case conference when several agencies are involved and either changes within the family or proposed changes in the providers' involvement warrant group discussion.

We have recorded the number of institutions that NSSI has contacted on behalf of client families. Representing a range of human services, these agencies include hospitals and clinics, legal services schools, and public housing offices as well as social welfare agencies; and, although most contacts relate to the needs of client children, a substantial number involve services to their parents, particularly their mothers.

Unfortunately, our initial data collection system did not record the number of repeated contacts on behalf of individual families with different institutions so the figures we report in this section do not differentiate between agencies NSSI contacted once and those contacted fifty times. Furthermore, we have only counted each institution once in each category even if we contacted it on behalf of ten different families. After this data was collected, we became aware how incompletely our contacts with other agencies were documented and we developed a new "agency contact form." This allows a client family's Case Manager to keep track of who she has spoken to about a family, and it will help us learn which families and which agencies require most coordination. Given these limitations, the data confirms our impression that we have many contacts with a few providers in the Division of Community Health at Somerville Hospital, but that other health providers are scattered.

Although NSSI contacted forty-three physicians, only two worked with families in all three categories, and only seven were responsible for children in two categories. Clearly, this geographic area offers patients an impressive variety of medical specialists.

Adjusting for the number of families, the number of institutions involved with families in Categories I and II is the same but the number of institutions involved with families in Category III is less than two-thirds what one would expect. Actually, this is not surprising, considering that many of the children in this group are not at risk medically and also that many of their families can be characterized as multi-problem and, therefore, apt to be more heavily involved with a smaller number of comprehensive, social welfare agencies. Similarly, the column that differentiates categories according to the number of referrals NSSI made suggests that families of children at biologic risk were unfamiliar with the social service network and also perhaps learning, by taking their child to a series of specialists, whether the "at risk" status would be confirmed. It is also true, however, that the fact that families in all categories have contact with an impressive number of agencies and institutions suggests again that these categories differentiate the caseload less completely than we had hoped.

The Range of Contacts
Between NSSI and Other Institutions
(2/76-3/79)

	I Established Risk (18 families)	II Biologic Risk (24 families)	III Environmental Risk (33 families)
Total # institutions contacted for all families	50	66	58
Range of NSSI referrals to institutions for a family	0-6	0-11	0-6
Range of contacts between NSSI & medical personnel for a family	1-9	1-5	1-4
Range of contact between NSSI & soc. or educ. agencies for a family	0-7	0-7	0-6

In addition to contacting agencies about families, NSSI staff are resources about agencies for families. Not only do they need to explain how systems work; for instance, what the difference is between public housing and leased housing, how one can apply for WIC coupons, foodstamps, and SSI benefits, but they also help families decide what services they need. For instance, Core Mothers have visited prospective family day care homes and preschools with clients, and they have learned what kind of counselling is offered by which agencies. Some Core Mothers developed a personal network of contacts in agencies who became their resources about service availability. These individuals may ask Core Mothers to contact families since agencies often report that NSSI workers are more persistent and more effective with families who are inaccessible to more traditional providers.

Social Service coordination assumes more of a case manager's time than had been anticipated. NSSI's intervention with a mother and child can be more individualized, and more focused when the goals and roles of other helping agencies are understood. When a family consents, providers in another agency can interpret the history of their assistance to a family. Providers tell us that NSSI's information about the relationship between the client mothers and their children is unique in its specificity, its detail and its intimacy. Since NSSI's involvement with a family is limited by the age of the child, and because families may require social services after their child becomes three, NSSI tries to help families establish relationships with other providers. Effective initial coordination helps families and staff plan what families will need after they terminate their relationship with NSSI.

F. Activities for Parents

NSSI's planners, administrators and direct service staff have hoped that offering group activities would decrease parents' isolation, enlarge their social network and help them to gain both confidence and skill in managing their children's behavior.

Later, an additional goal which was advanced was increasing parents' commitment to NSSI so that they would participate in fundraising activities designed to insure continuation of services when federal demonstration funds ended. However, anticipating and maintaining participation in parent activities has been extremely difficult.

In retrospect, we can speculate about the sources of some of the difficulties. First, some activities were poorly conceived and aimed to satisfy too many goals at the same time. Sometimes neither staff nor parents were clear in advance about whether a particular event was recreational educational, or therapeutic. Therefore, they did not know what to expect from them and it was also hard to evaluate the outcome.

Second, parent groups require ancillary services such as child care and transportation that NSSI was not always able to provide. Third, isolated parents have often played an active role in their own isolation so that they were often extremely shy about meeting other mothers. If parents were depressed, accepting NSSI's services might confirm their doubts about themselves or their children and make them feel more vulnerable. Perhaps a home visiting program like NSSI that offers long-term individualized relationships may reinforce clients' reluctance to leave their own homes.

We have wondered what effect an NSSI drop-in center for mothers and children would have had on clients' social relationships. Initially, however, NSSI staff would not have committed the time and money such a facility requires since its goals seemed unfocused, and their attainment unmeasurable. Impatient to educate and effect change in parents, we sought to organize their interactions.

Two phases have characterized NSSI's services to parents. From January, 1977 through June, 1978 we followed the plan of our initial proposal and sponsored a weekly mothers' support group. Conceived by the guidance counselor who served very briefly as the project director and who had intended to lead it, the group included both client mothers and Core Mothers. When the Director was terminated, our consultants at the Somerville-Cambridge Mental Health and Mental Retardation Center recommended an experienced Community Mental Health worker from the Preschool Unit as group leader.

Between January and June of 1977, we offered clients payment for child care in their own homes if they attended mothers' group. We tried to find sitters and to reimburse sitters they knew. Our efforts to generate both names for a babysitting pool involved extensive outreach to area elderly centers and to the local high schools, and was largely unsuccessful. One or two candidates from each group volunteered but then failed to appear at the NSSI office. Client mothers were reluctant to have someone they didn't know care for their children. In fact, they often relied exclusively on relatives for child care. During October, 1978 we spent a week in the high school, introducing the students in a tenth-grade home economics class to NSSI. One student from a class of twenty volunteered to babysit but subsequently was unavailable; we later discovered that the $1.25/hour we offered was substantially less than students could make at a regular, after-school job. Overall, our most reliable source of babysitters has been Core Mothers' own children. Often, for the support group two or three client children were transported to a Core Mother's house where they were watched by a team of her thirteen-year-old daughter, her own neighborhood babysitter and, if necessary, her mother. Our impression is that these particular persons volunteered because they had heard many stories about the client children and were genuinely eager to meet them.

From September, 1977 through June, 1978, NSSI administrative staff offered child care in a room adjacent to the mothers' group, using the time as an opportunity to try out activities, to play with children, to renew contacts with parents and occasionally, to model for Core Mothers. Organizing the group proved time-consuming: Core Mothers called their clients each week to encourage attendance, to determine who would attend, and whether they needed transportation and child care. Administrative staff determined who would be needed for child care. Attendance varied from five to fourteen mothers, always including at least three Core Mothers.

The design of the group itself raised problems that were never satisfactorily resolved, although since it had been given a major role in the initial proposal the Director felt obliged to continue it for a year and a half. The underlying assumption that ongoing participation in the same support group would increase identification between client mothers and Core Mothers overlooked the fact that although Core Mothers offered a kind of peer support, they were also salaried workers whose job with NSSI required them to build relationships with designated clients and whose participation in the group was a function of their job. Core Mothers saw themselves as helpers who might function quite differently with individual clients and who were reluctant to expose themselves to a group that included clients by asking for help. The fact that they had been hired as Core Mothers affirmed their success as mothers, whereas clients, by definition, needed support. Core Mothers did enjoy meeting each other's clients at the group, and often their curiosity was nourished by prior reports. The leader, however, saw Core Mothers and Client Mothers as equal group members although she reported that Core Mothers always sat next to their clients and usually participated less.

The four to six clients who attended regularly said they enjoyed having Core Mothers present; one related that the group gave her Core Mother a chance to learn about her clients in a different setting. None of the group members had participated in a support group before and their initial excitement and curiosity turned to frustration that the leader was not more assertive and instructional; no one, however, was willing to discuss her dissatisfaction with the leader. The leader admitted that the group was difficult to focus, perhaps partly because the clients were very different, ranging from parents whose children had severe physical handicaps to parents whose children were at risk of abuse or neglect. Finally, in the spring of 1978, the leader decided to offer a short-term, focused group for only client parents. Also for the first time she required mothers to commit themselves to attend all of the six sessions. A group of six volunteered but unfortunately the group was never offered because the leader was subsequently injured and unavailable.

In August, 1978, with funding from CETA, NSSI hired a Public Service Employee as parent coordinator. Using the former group leader as a consultant, she implemented a different kind of parent activities program for NSSI. A well-attended pot luck supper in the spring of 1978 persuaded us to separate social events from workshops which had educational goals. We decided to offer parents several workshops and workshop series whose content would be clearly identified in advance.

Early in the Fall of 1978 we sent a needs assessment to all NSSI clients inquiring about possible topics for future workshops. The parent coordinator also introduced the idea of a Parent Advisory Board (PAB) and solicited the participation of mothers. With her facilitations, the PAB had two goals: first, to be a resource to the NSSI staff about what parents wanted from the program and, second, to provide some leadership for fund-raising activities. The workshops that took place in the ensuing months were organized according to the responses of the needs assessment as well as ideas generated at PAB meetings. They are listed along with their attendance in the table that follows. Parents attended activities that sounded more sociable and entertaining. Workshops presenting information were less attractive. Transportation continued to be a problem for many parents and often had to be provided by NSSI staff who also always provided child care. Staff felt that access to a van would have resulted in transportation that was safer and more reliable. We were impressed by the increasingly regular attendance at all events by PAB members. It is not clear whether the individuals who joined PAB were more gregarious to begin with or whether the organizational identification it provided prompted participation at other events. The parent coordinator felt that scheduling PAB meetings in the evening at private homes prompted attendance. The NSSI fair planned by PAB, which took place in June, 1979, was an outstanding success. Not only was it attended by more than 350 people who contributed more than $800, but it increased NSSI's visibility in the community.

Hiring a parent coordinator who could devote time to parent issues resulted in parent activities which were more varied and numerous. She maintained contact with parents by phone and through a monthly newsletter. What proved more difficult was coordinating her contacts with families with those of Core Mothers. Sometimes clients felt barraged by calls from several different NSSI staff in one day. Unfortunately, the coordinator's time at NSSI was limited by her CETA contract, so we were not able to redesign her role. Membership in the Parent Advisory Board dwindled when the coordinator's time was reduced and when two of the most active parents left NSSI because their children no longer needed intervention. Since June 1979, group activities for parents have occurred less frequently, although we have sponsored two social events and two toymaking workshops for parents of children under one.

Summary of Parent Activities
Fall 1978-Fall 1979

Date	Activity	# Sessions in Activity	Total # Persons Attending	Av. Attendance per Session	PAB Member Participation
Fall 78					
	Toddler Swimming	8	7	3-4	0
	CP Workshop	1	6	NA	0
	Toddler Discipline	5	4	3+	3
	Potluck Supper	1	25+	NA	0
Winter 78/9					
	Toymaking Workshop	3	23	7+	3
	Coping w/Xmas Wkshp.	3	10	7+	0
	Xmas Party	1	35	NA	0
Spring 79					
	Potluck Supper	1	25	NA	4
	Assertiveness Training	4	6	3	3
	Toddler Swimming	5	6	4	4
	PAB Fundraising Fair	1	350	NA	7
Summer 79					
	NOTHING OFFERED				
Fall 79					
	Potluck Dinner	1	17	NA	4
Winter 79					
	Xmas Party	1	40	NA	5

VI. Analysis of Service Utilization Data

A. Service Utilization.

By individualizing services, NSSI staff aimed to be responsive to clients' needs. However, with a population that included a significant number of multi-problem, chronically dependent families, it was sometimes difficult for staff to prioritize their clients' needs. Flexibility about service delivery meant that we could be responsive to families in crisis but it also meant that staff had to decide which families needed what intervention. The absence of institutional rules about service delivery sometimes prompted lengthy staff consultation about what should happen to a particular family. Should they get what they wanted? If what they wanted was in conflict with what we offered, were we compromising their values and promoting our own? Was it equitable for an agency to offer different fmailies essentially different programs? How different were individual Core Mothers? The implications of our flexibility are discussed at greater length in the evaluation section of the report but are introduced here to suggest the questions we had when we collected service utilization data. First we will present and discuss average utilization of NSSI services by category and subgroup. Individual service utilization data for each client family is included in the Appendix, G . Second, we will discuss variations in service delivery by Core Mother.

At the outset it is important to outline what the figures in the chart represent and what their limitations are. Within each sub-group we first figured what the average monthly utilization of each service was for each client, current or terminated, as of March 31, 1979 and then we figured the average of these averages for each group. Initially we did not have a special medical visit report form and our early client contact forms did not require home visitors to routinely differentiate between respite and home visits. Thus, in reviewing the individual files to compile utilization data, we may inadvertently have counted a few respite or medical contacts as home visits. Each sub-group includes clients whom we see currently as well as clients who have terminated their relationship with NSSI; presumably, the average incidence of contacts is lowered by the client in which we deferred fromal termination but decreased contact substantially. On the other hand, average incidence may be inflated by those families whom we began visiting most recently, since we suspect that families have most intense and varied involvement when they are first involved with NSSI. Combining current and terminated families also means that the numbers in the column which lists average length of time

NSSI DELIVERY OF MAJOR SERVICES TO FAMILIES, AVERAGED BY MONTH
12/76-3/31/79

RISK CATEGORIES	NUMBER OF CHILDREN	AVERAGE NUMBER OF MONTHS IN NSSI	HOME VISITS AVERAGE NUMBER/ MONTH	MEDICAL CONTACTS AVERAGE NUMBER/ MONTH	RESPITE AVERAGE NUMBER/ MONTH	TOTAL CONTACTS AVERAGE NUMBER/ MONTH
I. Established Risk						
Brain Dysfunction	4	15	2.4	.24	.25	2.89
Congenital Anomalies	7	14	2.97	.29	.17	3.43
Diagnosed CP	4	13	2	.57	.28	2.85
Genetic Syndrome	2	15	3.95	.56	0	4.51
Visually Impaired	1	1	1	0	0	1
II. Biologic Risk						
Abnormal Muscle Tone	8	8	2.85	.82	.17	3.84
Congenital Virus	1	24	1.6	0	0	1.6
Failure to Thrive	4	15	2.73	.39	.61	3.73
Motor Delay	1	17	2.94	.59	.82	4.35
Neonatal Complications	3	8	2.1	.93	.43	3.46
Prematurity	4	6	2.68	.05	.74	3.47
Seizure Disorder	4	9	2.26	.14	.85	3.25
III. Environmental Risk						
Abuse or Neglect	11	5	3.97	.25	.21	4.43
Language Delay	10	8.5	2.67	.33	.25	3.25
Medical Coordination	2	1.5	3.25	.5	0	3.75
Parenting Support	6	2	2.56	.11	.2	2.87
Toddler Negativism	4	3	2.8	0	0	2.8

in the program are not final and can not be interpreted to indicate how long children with different diagnoses should have NSSI services but rather may help interpret figures on the incidence columns. Finally, the small size of nearly all the sub-groups means that the averages are highly susceptible to individual variation. With these cautions in mind, we can consider what these figures suggest about delivery and utilization of NSSI services.

1. Families in NSSI receive home visits more often than either respite care or transportation to and support at medical visits.
2. Families in NSSI are somewhat more likely to receive transportation and support at medical appointments than respite care.
3. Families which include children at biologic risk (Category II) are most likely to receive transportation to and support at medical appointments.
4. Families may receive a varying amount of service but overall few families receive more than four contacts per month.
5. Families show different patterns of utilization of NSSI services but the average overall number of contacts per month is virtually identical for each category of risk.

1. Families in NSSI receive home visits more often than either respite care or transportation to and support at medical appointments.

When one compares the range of medical contacts families receive to the range of home visits it underlines the program's focus on home visits. During the twenty-eight months when this data was gathered, one family received seventy-six home visits, eleven families (14%) were visited more than fifty times and twelve families more than twenty home visits. Only two families were transported and supported at medical appointments more than twenty times, three families more than ten but less than twenty times, and eleven families were supported at between five and ten contacts with health providers.

Though there were no families who did not receive home visits, almost half (48.6%) of the families received no assistance with medical appointments. Although this group includes families to whom these services were not offered as well as families who declined them, it does suggest that for both staff and clients the home visit is seen as the crucial program unit. For only one family did support at medical appointments represent more than a third of their NSSI contacts and for fully two thirds of the families who did receive support at medical appointments, that support represents no more than

15% of their NSSI contacts and at least 85% of their contacts were through home visits and respite.

2. Families in NSSI are somewhat more likely to receive transportation and support at medical appointments than respite care.

Of the five subgroups (including families whose children were visually impaired, had a genetic syndrome, had a congenital virus, or in which parents needed support with toddler negativism or with medical coordination and translation) in which families received no respite care, only three subgroups (including families whose children were visually impaired, had a congenital virus, or in which parents needed support with toddlers) also received no NSSI support at medical contacts. Two of these subgroups include only one client.

In the subgroups where NSSI Core Mothers offer transportation and support at medical contacts and also provide respite, the average number of medical contacts are higher than the average number of respite contacts in seven of twelve subgroups. Considering individual families we find that 59% receive no respite care compared with 49% who received no assistance at medical appointments.

Staff report that increasingly they see respite care as an occasional service that is most likely to be offered to families during episodes of unusual stress whereas support at medical appointments remains a high priority.

3. Families which include children at biologic risk (Category II) are most likely to receive transportation and support at medical appointments.

As indicated in the discussion of coordination of services we speculate that the uncertain prognosis of children who fall in Category II increases the number of contacts these families seek. Children who are at established risk (Category I) often have a diagnosis at the time of referral so that the small number of medical contacts may be because the child either does not need additional consultations or the parents may have established satisfactory relationships with health providers independently. In the category which includes families whose children are at environmental risk (Category III), children are usually not at medical risk and if support and transportation is provided for preventive health maintenance, a goal of NSSI is that parents follow up with their health provider for themselves. In addition, the average utilization figures are lower for this category since we characterized more than half of the families as "short-term" clients and did not offer them transportation when they joined NSSI.

4. Families may receive a varying amount of service but overall few families receive more than four contacts per month.

The average number of contacts per month for individual families ranges from one to ten, however only three out of seventy-six families were contacted on the average seven or more times each month. The intensity of NSSI's involvement with individual families varies from month to month but periods of intense involvement when a Core Mother sees a family four times in one week are rare.

5. Families show different patterns of utilization of NSSI services but the average overall number of contacts per month is virtually identical for each category.

After only a minor manipulation[1] we calculate that, overall, families whose children are at established risk and those whose children are at environmental risk (Categories I and III) receive 3.42 contacts per month and families whose children are at biologic risk receive an average of 3.38 contacts per month. This similarity was unexpected because of the variations that appeared between the categories in total number of respite contacts, home visit contacts and transportation contacts. This reflects that Core Mothers appear to equalize their delivery of services to individual families; however, since these figures combine the work of inexperienced and experienced Core Mothers, we cannot assess whether workers become more likely to provide service differentially. The similarity of contacts across families also shows that these categories of risk do not clearly distinguish families.

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[1] Simply omitting the visually impaired subgroup from the category that includes children at established risk (I) because the mother moved suddenly and without notice after our only successful contact.

B. The Incidence of "No Shows"

Most NSSI Core Mothers maintained regular contact with most of their clients; sometimes, however, a home visit was cancelled. Although we tried to record cancellations, we have not compiled this data because our original forms did not differentiate between cancellations made in advance by either the client or the Core Mother or those occasions when the client was not at home for a pre-arranged appointment, all of which we designated as "No Shows." Furthermore, several "No Show" forms were sometimes filled out when a Core Mother tried repeatedly to see a client even though her successive attempts were not in the form of pre-arranged appointments. In other words, we not only did not know the conditions under which the Core Mother learned that a contact would not occur, but also our record-keeping did not identify the reason why the contact had not occurred. For instance, repeated no shows can be interpreted to mean that a mother is unhappy, that she doesn't like the home visitor or that she wants to leave NSSI. She may be depressed, tranquilized or inebriated. She may have simply forgotten the time or date of the appointment. On the other hand, perhaps she is not at home, because she has had to attend to a family emergency. That is, without information about the initiation of and the reason for the lack of contact, we have no way of assessing continuation of service.

No shows are disappointing and frustrating to the Core Mother. Occasionally when a Core Mother had a number of no shows, we began to wonder whether she was in fact making appointments with clients or just dropping in. Our impression is that clients who are referred to NSSI but who are ambivalent about accepting services are not apt to be at home for their Core Mother's initial visits. The data that we did collect shows no significant difference in the incidence of no shows in each of the three categories of risk.

Our experience suggests that it is important to differentiate this category into cancellations made in advance by staff person, and by client families, and "No Shows," in which one of these parties does not inform the other, designating who it was.

We recommend the recording of No Shows to other programs, because of the information they provide about the functioning of individual families, and therefore the value of continuing services to those families, and also as a possible measure of staff patterns of making and maintaining relationships.

C. Individual Patterns of Service Delivery

Because we are interested in learning to what extent service utilization is a function of service delivery, that is, the decisions of each individual worker, we have analysed data by individual Core Mother. Of course, NSSI's initial difficulties with early record keeping and classification of services apply as problems with this data. Additionally, we are combining new Core Mothers, more experienced ones and Core Mothers who resigned from NSSI after two years.

Overall, most of the variations by Core Mother and by family "make sense." Not only are there many ways to skin a cat but administrative staff have learned to appreciate that one of the luxuries of a small program whose direct service staff are paraprofessional and functioning responsively is its ability to support and encourage individual styles of service delivery. High amounts of a particular service service worried us only occasionally; on the other hand, some of the variations across Core Mothers seem noticeably large and have raised concern especially when the incidence of service delivery is particularly low. The following observations we can make from our data on individual patterns of service delivery of Core Mothers seem worth suggesting because of their implications for both supervision and training in similar programs.

1. Core Mothers differ most in the delivery of respite care, second most in the number of times they accompany clients at medical appointments, and least in the incidence of home visits they maintain.
2. Core Mothers provide frequent respite to families who also receive many home visits.
3. Recently hired Core Mothers provide more transportation and support at doctors' visits.
4. The widest variation between the average number of home visits provided by individual Core Mothers occurs in families whose children are at environmental risk (Category III). The widest variation between the average amount of respite and transportation and support at medical appointments occurs in families with children at biologic risk (Category II).

1. Core Mothers differ most in delivery of respite care.

Delivery of respite is much more individualized than other services. Variation in service delivery is shown clearly by contrasting range of contacts; for instance, one Core Mother provided the highest amounts of respite to three individual families: one family received 35 respite visits (2.3 per month) and another received 16 respites (.82 per month). This

Core Mother provided highest amounts of respite to long-term NSSI families in which isolated mothers clearly stated their need for relief and had no other source of child care. Three other Core Mothers provided more than ten of their respite contacts to just seven individual families. With one exception,[1] the range of average respite contacts is less than once a month (.5 to .8 per month).

Variation in incidence of transportation and support at medical appointments reflects the preference and interest of individual Core Mothers in this aspect of the program as well as their level of confidence about first, physically locating the medical facility and, second, talking to the health provider.

During the period when this data was collected, the number of medical visits completed by each Core Mother ranged from 45 to 10 and the average number per client ranged from one Core Mother's high of 4.5 visits to another Core Mother's low of .83 visits a month per client. The latter Core Mother had the lowest average rate of medical visits to families whose children's risk was established and biologic (Category I and Category II) so she apparently declined consistently to provide this service.

2. Core Mothers provide most respite to families who receive most home visits.

This reflects how, initially at least, NSSI staff did not differentiate families' needs but rather assumed that high need families should have all possible services. Also, it suggests that both offering and accepting respite services may require the extra familiarity that comes from many home visits to a long-term client.

Respite is sometimes requested in advance by a client mother; more often, however, the Core Mother reminds the mother of its availability after she has decided that respite would be helpful to the mother, usually based on an assessment of changes in the mother's ability to cope.

3. New Core Mothers provide more transportation and support at doctors' visits.

Our impression is that recently hired Core Mothers are often most confident offering services to families that are concrete and structured and our further impression is that new families may also request these services. In addition, the high incidence of transportation and support at medical appointments is a function of individual client needs and new workers' particular reluctance to deny clients' requests.

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[1] This exception aimed to facilitate the client's attachment to another agency's social worker by providing regular respite at the end of NSSI's involvement.

Clearly, this is a service that can be provided with varying degrees of complexity and intensity, depending on how much time the Core Mother spends reviewing and preparing with the client for the appointment and whether she participates in the discussion of the examination with the client and the provider. A new Core Mother may begin by offering only the most concrete aspects of this service such as transportation, help carrying the baby, and help watching siblings and intervene more actively with the health provider as she gains confidence.

4. The widest variation across Core Mothers in the provision of home visits occurs to families whose children are at environmental risk (Category III). The widest variation in provision of other services occurs with respect to families whose children are at biologic risk (Category II).

These variations suggest the range of reactions that individual Core Mothers had to clients in particular categories and also, perhaps, the range of needs within categories. Families whom we have characterized as including children at environmental risk (Category III) may have a variety of problems that bear on the child only indirectly. For instance, families in this category are more likely to experience chronic difficulties with sub-standard housing, recurrent adult hospitalizations, as well as trouble finding and maintaining adequate employment. Individual Core Mothers vary in the extent of their responsiveness to these problems; while, especially in the program's first year, some workers were very eager to provide considerable concrete assistance to families, other workers have wanted to clarify their role with the mother and the child and be available as a resource for other problems.

Variation within this group is also a consequence of a program decision about which services were offered to those families whom we initially characterized as short-term. We rarely provided transporatation or respite to these families because we felt uncomfortable offering many services and then withdrawing them a few months later. The high incidence of home visits may reflect Core Mothers' exclusive focus on that contact as a way of establishing the necessary relationship with the client mother, or, perhaps, the time limit to their involvement made each visit seem more important.

The variations in Category II seem to reflect clients' needs--two families had a lengthy diagnosis, workups involving several assessments, and who were fascinated by health providers--and they both had the same new Core Mother who enjoyed beginning her relationships with families by providing concrete services like transportation and support.

D. Parent Satisfaction Measures

In order to learn what families think about NSSI services we have administered several different questionnaires. At the end of the first year we mailed out evaluative forms to be completed by the client and returned to our office; during the second year we developed a termination questionnaire which home visitors filled out at their final visit to a family, and, during the third year, we administered a parent satisfaction questionnaire after each developmental evaluation of the NSSI child to help in writing the next Individual Program Plan. These questionnaires all sought to illuminate any differences between NSSI's assumptions about services and parent expectations and experiences. We particularly focused on what parents had liked best and what program changes they would recommend. Not surprisingly, the most recent parent satisfaction form for clients who will remain in the program includes the most specific and concrete questions about service delivery. Not only had we learned what kind of questions prompted detailed answers, but also, since families were continuing with NSSI we wanted to respond to their recommendations.

In this section of the final report we will describe what happened with yet another satisfaction measure we developed to follow-up the thirty-seven client families who had terminated their relationship with NSSI as of March 31, 1979. With these terminated families we wished to learn both what they had liked and not liked about NSSI, whether client children were currently enrolled in an educational program, and when they had last seen a health provider. Although we risked compromising the candor of the responses, we decided that it made most sense for the Core Mother who had worked with a particular family to conduct their interview. If the Core Mother was no longer employed by NSSI, the family was assigned to an administrative staff member who had had some contact with the family. We considered using staff that were unfamiliar to families as interviewers but decided against it as we thought it carried a larger risk of incomplete and inadequate responses. We hoped that because families no longer depended on NSSI for services they would be able to share both their enthusiastic and their less enthusiastic recollections fully. Most parents were interviewed by telephone, although a few questionnaires were filled out either at home visits or in the NSSI office.

We were able to contact 27 (73%) of these former NSSI families, which included 29 children. Of the ten (27%) families whom we failed to reach, six had moved away from Somerville, and four families in Somerville did not have phones and did not respond to our written requests. We did also write to four of the families who had moved and received no response. We did not contact two families in which the

NSSI child had died.

From our telephone contacts, we learned that a majority of our former clients (seventeen children, or 59%) are currently in some kind of regular school or day care program. Thirteen of these children attend school or day care at least four days a week, and are scattered in seven centers and two family day care systems in four cities which reflects how hard families and providers in our area have to look for appropriate child care. Eight of the children (47%) are in special education facilities while nine are in programs that serve both handicapped and non-handicapped children. Only two of the sixteen parents voiced any reservations about their child's school program. Three children (10%) are currently in temporary foster care. Nine former NSSI children are at home and not enrolled in a program.

Most client parents (88%) appear to be fairly satisfied, regular consumers of local health care facilities. In fact, twenty-three (85%) were able to recall a sick or well-child visit within the last six months.

Most comments about NSSI services were positive but we cannot know what per cent of this is attributable to their Core Mother coordinating the interview. Only four former clients had distinctly negative feedback and a fifth woman said she was unable to remember anything about the program. The most negative comments were from a woman whose child had been placed in foster care at NSSI's recommendation and against her wishes; one mother said she preferred the professional home visitor who had come from the Visiting Nurses Association to see the younger sibling of the NSSI child, and another woman said she had found the NSSI mothers' support group boring.

Most mothers spoke positively of the support and companionship the Core Mothers' visits provided. They liked having someone to talk to; one mother said, "She helped me as much as the kids. I could tell her my problems and I could get it off my back." Many mothers did describe watching the child's development; several who had older children asserted that they had noticed and understood more about children when they had an NSSI home visitor. They remembered liking her attention themselves and they knew it had been good for their children. Many mothers appreciated the fact that services were home-based; most mentioned how convenient it was for them not to travel but one mother also said she liked watching the Core Mother work with her child.

Three families re-referred themselves to NSSI as we interviewed them. Two of these three were interested in developmental re-evaluation and consultation about appropriate alternative services while the third really wanted on-going home visiting.

Some parents we spoke with said they especially missed the mother's group while others said they liked referrals to other agencies. One mother mentioned the program's responsiveness: "I used to call a doctor but I started calling you. You answered things right away." Only two mothers specifically appreciated the instructional aspect of interventions, although several clients mentioned toys and articles about development. Although not specific, many parents did feel NSSI had affected their child's development. "I wouldn't have known what to do without your telling me. She was just lying on her back and you got her crawling," said one, while another mother asserted, "I think she's a lot smarter than if she hadn't been in the program," and yet another recalled, "You made me look at the whole child--not just the disability."

VII. Project Evaluation

A. Assumptions and Strategies

The evaluation process that NSSI has engaged in from October of 1978 to December of 1979 has rested on several assumptions. The major one is that formative rather than summative evaluation is more useful to beginning and/or innovative programs for two reasons. First, NSSI staff had finally decided that they would not be able to answer global questions about impact and effectiveness until they knew, in some detail, what the program inputs were. Second, the identified evaluator convinced NSSI staff that formative evaluation would be most useful to the project. Accordingly, NSSI's evaluator was regularly involved over a long period of time and took on a quasi-staff function (Glaser and Becker call this "observer as participant").[1]

Formative evaluation requires that an evaluator be very familiar with a program and its staff. Customarily, the term formative has been used to describe the evaluation process in which information is continually fed back into the original questions to reformulate them and thereby gather new information. However, "formative" also applies to the effects the evaluation has on the program. Theoretically, it would undergo changes and modifications as it is informed by the evaluation process.

There are several common objections to this sort of an evaluation: 1) it is expensive 2) staff at all levels need to be involved and 3) it may not meet the guidelines of the funding agency for assessing effectiveness.

As for expense, an evaluator's longterm involvement in a project can clearly exceed the usual 5% of a total budget allotted to it in, for example, state funding and can easily reach a 15% level. However, the purposes of formative evaluation and the uses a program can make of it are not unlike the results expected from consultation. If budget categories are conceptualized in terms of their functions and services to the program, the cost of formative evaluation services might justifiably be sought from other sources within the budget. Viewed in this way, formative evaluation can become more possible as a program option with more potential cost benefit.

As to the second objection--the involvement of staff, also an additional cost--its source rests on the assumption that evaluation is a specialized kind of knowledge wielded by experts in whom one must place blind faith. Evaluators seek their own information to which the program has little input, mysteriously jiggle numbers and as a result make final judgments about program effectiveness. The staff leaves them alone and they leave the staff alone. In the case of summative evaluation, this may be described as a proper and necessary relationship between evaluation and program but in our view it is not applicable to a program such as NSSI's for two reasons: the program is new, and it is a human services program.

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[1] "Participant Observation," Glaser, Edward M. and Becker, Thomas E., Eval., 1:3/.9/73, p. 47.

As a new program transforms a plan "on paper' into actual operation it makes many rapid adjustments to circumstances, populations, other institutions, etc., which often cannot be anticipated in the conceptual stage. It is therefore difficult to both identify in advance, or even in the first years of operation, which variables are significant. It is more useful to try to identify what the program variables may be. Human services programs, in particular, do not easily lend themselves to the collection of orderly consistent incoming data or quantifiable manipulations. Documenting how a new program becomes a "service" whose components and staff share some consistency is a precursor to making any summative evaluation of the program's ultimate effectiveness. Formative evaluation requires involvement with the staff because only they can provide information about what the program is. For the evaluator to obtain that information he/she needs to be trusted which in turn requires contact over time. These conditions can only be offered by an evaluator who is "local" or sufficiently nearby geographically and who can flexibly arrange his/her schedule to follow the range of program events occurring at different times.

In addition, the bias of NSSI's evaluator was that if program personnel do not learn from an evaluation, it is a relatively meaningless effort. Evaluation traditionally seeks a product (answer) in regard to program effectiveness, and views the general public and/or sponsoring agency as the consumer who will utilize the information. NSSI's evaluator's bias was that there was relatively little impact on either of these or on program policy based on her experience with even large scale evaluation. In her view, evaluation's greatest impact was on those persons who became involved with asking evaluation questions. Among those persons, program administrators had the greatest potential to utilize the "answers," such as they were. More importantly, it increased their interest in and ability to ask questions about their work, that is to become their own evaluator. In other words, NSSI's evaluator viewed evaluation as an educative process which had as its goal the improvement of a staff's skills to step back, look at their own program practices and procedures, and select which to modify and how. This conceptualization of evaluation views the process as an investment in persons and assumes they will use evaluation techniques as they move to other programs and present their ideas in other contexts.

Happily, NSSI's two administrators were responsive to this view of evaluation and, as a result, the evaluator moved from a critical, partial and distant role concerned with the past events of program history to a more active role which became more closely tied to program planning and staff development. As a group, we decided to focus on the task of describing the home visit Core Mothers make to client families, as we thought this the crucial aspect of program delivery. The first step we took was to have the evaluator discuss home visits with the total staff in an attempt to discover any program requirements and regularities among them--that is, those behaviors which might not be forfeited under any except the most unusual set of conditions. At this meeting, the two most experienced Core Mothers talked the most and indicated "family support" as the priority goal of the program. The form this took varied with each family, they said. This discussion was followed by the evaluator accompanying and observing the two most experienced Core Mothers on home visits. The remaining three Core Mothers had joined the staff approximately two months earlier and were reluctant to be observed, because they were new, but also because the program had not previously engaged in any direct monitoring or observation of home visits by anyone. After these initial observations the evaluator discussed them with the total staff. The Core Mothers expressed the view that it was important to visit different kinds of families and the evaluator made more visits followed again by discussion with the two most experienced Core Mothers. Finally she accompanied new Core Mothers on their visits. The evaluator intended to pursue this strategy to develop a role description of the Core Mother. She announced working assumptions to the staff: that she did not know what the program was, that the job of the Core Mother was a new one, which everyone was in the process of defining, and we hoped that these observations and discussions would help us arrive at a definition. There was an additional assumption that was not as clear to the evaluator at the time: that home visits would contain all the elements of the role.

It began to appear that the evaluator's observations were somewhat threatening to staff, new staff in particular. An administrative staff member reported one Core Mother had asked "Does she (the evaluator) think (the program) is good or bad?" An inexperienced Core Mother with whom the evaluator had not been able to talk immediately following the visit they had made together called her nervously the same night asking if "I'm doing it right." These staff members exhibited a typical response to evaluation which occurred in spite of the evaluator's stated purpose and behaviors. The feeling of being threatened and judged negatively is a common response to evaluation often ignored by an evaluator. We felt it worthwhile to explore alternative ways we might obtain the information we wanted. At this point, the evaluator and administrative staff reviewed their purposes. We wanted to know what the Core Mothers did as well as what they thought they did. Core Mothers were the only ones who could provide the information on their role but it was clear they needed another format in which to do it. In order to describe the parameters of a home visit, we needed to see each Core Mother interacting with several different families.

Who were the other persons to observe who could obtain that information? Core mothers themselves might prefer to act as each others' observers, but were not trained for this. Administration agreed with the evaluator that we could not afford to lose information. Therefore each Core Mother was observed by each of the other four Core Mothers and by one of the two administrators. The observer's assignment was to report what happened on the home visit. NSSI staff made fifteen observational home visits and every person on the staff was exposed to every other person's work and articulation of the role of the Core Mother. We thought the perspectives of both Core Mothers and Administrators would provide us with interesting and different information. These observations were followed, usually immediately, by one to two hour discussions between the Core Mother, observer and the evaluator. We thought small group discussions would provide more information than the large group ones had. Also they were a more cost effective use of the evaluator's time. Presumably, she would notice "themes" as she was present at all discussions.

B. The Role of the Core Mother

The task of producing a description of a role carries with it the implication that if various people are implementing the role, it is in some way replicable and they must or will share certain behaviors as a result. There is some overlap in the five Core Mothers' enactment of their role, i.e., the specific behaviors in which they engage, particularly their presentation of interventions where there is a good deal of duplication of strategies and goals.

When the behaviors we observed were compiled, they raised a series of questions. One was whether there was any difference in the behavior in which a Core Mother engaged which a professional might not. Intuitively, we thought the answer to this was clearly "yes" but divided behaviors into categories: those behaviors shared with professionals, those behaviors which were usually not shared with professionals, and behaviors which administration felt were not supportive of the program. The categories and their behaviors follow.

I. Behaviors which Core Mothers[1] Share with Professionals

a. Contact is usually scheduled and during the daytime.
b. There are limitations on socializing (e.g., no bowling, shopping, movies).
c. The relationship is assumed to be in the control of the CM (the CM initiates most contacts).
d. The CM has access to professional records concerning the child.
e. The CM engages in limited, if any, reciprocity of personal confidences.
f. The CM advocates for the mother.
g. The CM does not express anger toward the mother.
h. CM accompanies mothers as well as advocates and intervenes for them in many institutions, hospitals, court, welfare, etc.
i. CMs invite mothers to NSSI social gatherings.
j. CMs help the mother become aware of those agencies and services with which she may not have availed herself (Medicaid, housing, etc.).
k. CM attempts to limit her contact with the father when alone with him.
l. The CM continuously monitors the child's health; makes requests for feedback from medical appointments.
m. The CM investigates, becomes knowledgeable about child's handicap.
n. The CM (and program) articulates developmental goals for the child, not for parent.
o. The CM resists saying "No, I can't..." (and losing client friendship).

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[1] The title Core Mother will be abbreviated to CM where it appears in these categories.

p. The CM is reluctant to enunciate standards of acceptable mothering and to confront client re "unacceptable" behavior.

II. Behaviors which seemed more typical of all the Core Mothers which professionals might not uniformly exhibit

a. CMs accept phone calls from clients at home as well as calling clients "after hours."
b. CMs bring physical goods to mother both at the mother's request and the Core Mother's initiative (e.g., food, clothes).
c. CMs provide babysitting (respite) at the mother's convenience.
d. CM's provide transportation.
e. CMs (often) plan special treats when the mother is depressed or when the child has achieved a particular milestone.
f. The CM expresses physical affection toward the client child.
g. The CM positions herself physically nearest to the client infant.
h. The CM talks to the parent through and for the child ("Oh, Mommy, I'm having fun with this game.")
i. The CM plans with the family for the program's periodic evaluations of the child's developmental progress, and often helps administer the evaluations.
j. The CM is willing to have her own family members and clients meet.
k. The CM informs and advises beyond the specific focus of the program (tells client about "good buys," refers to local repairmen, etc.).
l. The CM cares for other children in a client family (will take them on errands with her, e.g.).

In addition to these behaviors, there are behaviors which are exhibited now and then by all Core Mothers which program administrators (and sometimes other Core Mothers) view as either ill-advised or unacceptable. These characteristics were generated by the administrators.

III. Atypical Behaviors

A. The CM may exhibit "unfriendly" feelings toward clients (e.g., keep her coat on during visits, never accept coffee, tea, or soda, slip interventions through the door slot, not make regular appointments, "preach" to or lecture parent, complain in the office excessively about parent's standards.)

b. The CM becomes lax about requirements for documentation and general office (job) standards (e.g., not complete home visit reports, forget materials for home visit, postpone seeing unresponsive clients, come in late, leave early, not plan home visit, not develop interventions).
c. The CM has difficulty ending the home visit.
d. The CM overidentifies with the child, in some cases rendering her unable to work with a mother whom she judges unresponsive to the child.
e. The CM encourages dependence by: feeling responsible for solutions to all problems, providing too much concrete help (food, respite, parties), providing only hands-on services to child, listening to and sharing personal information, trying to solve personal dilemmas).
f. The CM assumes client shares her knowledge and goals, therefore doesn't explain interventions.
g. The CM hesitates to confront mother about lack of compliance (if any) with the "contract" she has made with NSSI.
h. The CM wants program administrators to approve all decisions.
i. The CM and client are unable to coordinate with other agency personnel.
j. The CM becomes immobilized (if client mother responds unexpectedly, Core Mother is unable to think of an alternative plan).
k. The CM does not ask for help when she feels confused.
l. The CM withholds information from administrative staff.
m. The CM feels she is "marking time" in home visits, is not clear why she says many things (goals).

These behaviors indicate that the administrators have "professional" kinds of standards for the Core Mothers. Interestingly, the operation of the program as it existed in 1978-79 acted somewhat as a deterrent to the enactment of these standards due to three factors: training, supervision and the definition of the administrative role.

Administration's ability to direct, modify, and/or intervene in the Core Mother/Client relationship was dependent on a frequent but not regularly scheduled one-to-one meeting between an administrator and a Core Mother. At this meeting, the Core Mother verbally reported her version of the events in her assigned families which was administration's only source of knowledge about program for supervision or case management, with the exception of periodic developmental evaluations. Administrators never went to NSSI homes and never accompanied Core Mothers on home visits. Since there was no "on site" supervision, there was neither a check on the accuracy of what was reported nor what was being omitted from Core Mother reports. In addition, a Home Visit Report[1] form to be filled out by the Core Mother did not include any request for self-reflection about performance. There was minimal training for the Core Mothers in various forms of reporting: either in making observations of adults, children, or interactions and virtually no formal training in oral reporting. Their only experience with this was a series of infant observations followed by written comments and discussion.

As is obvious, these particular practices combined to create a situation in which Core Mother decision making was both independent of administration as well as frequently "undiscovered" by it.[2] Accordingly, the Core Mother proceeded on an intuitive basis. The pattern of contact with families could be either very irregular or quite intense.

In the process of evaluation, the administrators became involved in making written observations of Core Mothers, as well as discussing Home Visits. This provided the evaluator, but more importantly, the staff, with a fuller picture of the Home Visit and Core Mother behavior during it.

In the course of these discussions between Core Mothers, administrators and the evaluator, several issues surfaced, which bore on the program and the enactment of the Core Mothers' role.

1. The Core Mothers' conception of their job priorities and responsibilities
2. Self-reported changes in job enactment (including the range of demands Core Mothers will make on clients and their expectations for themselves and clients around the presentation and learning of interventions)
3. The location of work and its repercussions

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[1] See Appendix

[2] For a natural account of this, see PS account of the C family in the Appendix

1. The Core Mothers' Conception of their Job Priorities and Responsibilities

NSSI's initial plan was that it would offer a program of assistance to handicapped infants from 0-3 years of age. This statement of purpose implies that intervention activities (exercise, play, etc.) are the primary vehicle for "remediation" and that the child is the direct target of the program. However, program formulation in this case blurred the fact that access to the child is dependent upon the parent. Further, there is an implication that is carried in the notion of intervention, even in cases of clear-cut physical handicapping, that their remediating power is in repetition and such regular practice can only be provided by someone in the home. This led the program head-on into an issue which all home visiting programs face: "How is the caretaker to be involved, instructed and/or to become the 'carrier' of the program?" Or if there is to be no home carrier, can program benefits exist without an informed "home" representative, i.e., the caretaker? Core Mothers, in reviewing the past as well as the present, clearly place first among job priorities establishing a relationship with the child's caretaker. If the choice were forced, this could supersede both attention to or establishing a relationship with the child and certainly any attention to interventions. Though frequently interventions serve as the vehicle for the relationship or the rationale for what the program will bring the parent, the Core Mothers judged that the nature of the families' multi-problems and the pressing concerns of many mothers were such that neither interventions nor the child could tolerably be the focus of the visit. In some cases, Core Mothers also found that, even in those cases where the mother and/or the family were not overwhelmed, bringing an intervention into the home, having an interaction around it and immediately leaving, was an uncomfortable format. It seemed awkward, particularly to a newly "trained" paraprofessional, to walk into a home, request that a mother and child perform a specific activity, perhaps model it, answer questions and walk out again after twenty minutes. It smacked too much of a professionalism that Core Mothers, as parents, were suspicious of. They were left with a feeling that there was something partial and uncivilized about such behavior. Core Mothers stayed longer than that twenty minutes and what was at first conceived of as "extra" or social time became part of the job and began to take a certain shape. A typical length of time to spend in a home quickly became about an hour.

The character of the relationship that has generally been established between Core Mothers and their "clients" seems to be determined by the interaction of three particular features of NSSI:

1) The "case load" for each Core Mother is small, no more than ten cases. A Core Mother is assigned new cases based on the difficulties her current families present and individual cases are not viewed as interchangeable and/or equal.

2) There are many ways in which Core Mothers are independent and define their own role.

3) There are similarities between Core Mothers and clients: each have handicapped children, are mothers, residents of the same community and from low income circumstances.

By preference, the independence of Core Mothers seems to lead them closer to the category of "friendship" with a client than the sort of relationship that might characterize that which a professional worker would have with a client. (The way in which Core Mothers express friendship and availability varies, probably more reliably with the experience of the Core Mother than with her individual personality.) There are relationships issues which show a difference between first year Core Mothers and those who are more experienced. First year Core Mothers seem to have a more difficult time identifying these, and therefore it is a second year Core Mother who speaks about them in the greatest detail.

"I don't want to fall into that role of just being a girlfriend...if we talk primarily about (the child) our roles are pretty clear." And again: "The client has asked me to go to a movie. It's difficult to say no thanks, and not damage the relationship."

The second year Core Mothers see that there should be some limitations to their role, usually in favor of promoting a client's independence rather than dependence. They are also more clear about focusing on the child and his/her development as the ultimate purpose of the program and it is more difficult to divert them from that goal. They talk about "coming back" to the subject in contacts with mothers. Sometimes they refer to these contacts as "interviews" or by a name that makes their role more distinct, as well as more distant.

It is a common occurrence for Core Mothers to give clients their home phone numbers. Some place explicit limits on the nature or time of calls but seem to do so on a case by case basis both within and across families. Some Core Mothers will also call clients. An extreme example at one end of the continuum is the Core Mother who called a client on the weekend to tell her that the kind of soup pot she had been looking for was going on sale at a local discount store. At the other end of the continuum might be the more usual and predictable call from a Core Mother to a client concerning the outcome of a medical visit.

The relatively small case load allows Core Mothers a great deal of flexibility to schedule clients both for their own convenience and the clients'. It also allows them to focus a great deal of attention on a single client during, for example, a series of particularly stressful events. This flexibility and the encouragement it offers the Core Mother and caretaker in mutually defining need and timing has a certain number of pitfalls for both, though perhaps because we talked with and observed Core Mothers more, we found it to be more of a disadvantage in their case. Coupled with the lack of prescription for the enactment of the role, the Core Mother makes many of her judgments about her work as she does in other aspects of her life. Since she has no definite set of work expectations to match against her "performance," social relations become a more dominant model against which to hold and judge the effect of her contact with clients. In one case, in exploring a first year Core Mother's feelings that she couldn't help a client and "...was never going to be a good one for her," it seemed to be partially explained in the Core Mother's mind by age differences (the Core Mother is approximately 30 and the client mother, 40), but also seemed influenced by the mother's being American born while the Core Mother is foreign born. In defining differences between clients and themselves, it is also interesting what ranges of difference Core Mothers will tolerate. One Core Mother says, making a negative judgment, "She (the client) has a different life style. She's not together. I can't explain it." Other Core Mothers report they can't really like a mother who doesn't care for her children. "...they (a family) might talk about one child--you know, 'This child is so funny'--whatever they say about the child is a downer, or 'He's so clumsy' or it's never something nice."

The judgments and attitudes Core Mothers have about interactions between parents and children can be quite distinct. One first year Core Mother says, "My heart aches for the mother. I don't even focus on the kid, I just go for the poor mother--that she could have these (negative) feelings." Whereas another Core Mother's attitude is to compare herself with her client and find herself wanting. "She (the mother) knows a lot about things...and I said, 'Gee, she knows a lot about... and I felt, 'I don't know nothing.'"

The issue which keeps surfacing in regard to the Core Mother role is what the limit of these responsibilities are and were there requests, either implicit or explicit, that clients might make which would (or should) be refused. Help in the case of illness and its attendant complications is rarely refused by Core Mothers. "If (the mother) had called and said she was sick or the baby was sick and had to go to the hospital, I would have gone over there and taken her. I would've changed my other appointment."

Again, there is a variety of attitudes found in the Core Mothers--one first year Core Mother with a large family said, "I would be more apt to find an alternative with a client than 'have Iris do it.' And I think in a job situation that it isn't good--if you have eight clients, to have all these clients calling you with these different things. I personally would not encourage that. Don't get me wrong. I don't mind. I've had people call and ask me advice. I would be going to sleep. I would be more apt to say to them, I would ask, 'When this happened before, who would you call?' It would be more apt to get thim thinking what they could do. I think it would exhaust me. I couldn't handle it...I would find alternative ways to help, but at first, always running... I couldn't...and function all day...I couldn't do it. That would drag me down."

The sensible practicality of this Core Mother who sees herself as a temporary support, helping families to identify more enduring past, present, and future supports in their own environment, especially in relation to a crisis, has a kind of hearty appeal. On the other hand stands the kind of exhaustive detailed care of Ruth, whose involvement extends at times to having clients and their family members sleep and eat at her house. (See appendix for a report of this Core Mother concerning her interaction with one family.)

2. Self-reported Changes

Both the three first year Core Mothers and the two second year Core Mothers reported changes they had experienced in their own feelings, perspectives and abilities. All report an initial feeling of wanting to like and be nice to their clients, which was translated as not making demands on the mother, and, at most, only requesting her permission for their actions in connection with their job. Another feature of initial CM behavior is revealed in this quote:

"Before, I would be nervous calling. At the phone call I would say, 'Could I make a home visit today at one?' And now, an alternative--'I will make a home visit tomorrow at 2 or would the morning be better?'" The appointment to visit was arranged for on the day of the visit--later, it was made a day or a week before the visit and the CM invited the mother to set a time if she wished, though within rather narrow boundaries. CMs seem to develop the ability to plan only as their anxieties decrease. Acquiring a more elaborate sense of their role contributes to this. Both second year Core Mothers report an increase in their directness with mothers as they become more experienced. One stated it became easier to say "We need the infant seat for someone else" or, in reference to the target child, " I want him off the bottle by Easter."

With these changes there is growth in conviction about the purposes of the program. Whereas all Core Mothers realize that interventions are of positive benefit to the child, and that it is important to know whether or not they have been used by the client mother during the period between NSSI contacts, initial CM behaviors all reduce themselves to a failure to follow up on these "assignments." At the most, they may ask, "How did the exercises go?" which is predictably answered, "Oh, fine" by the client. A second year CM reports her change of strategy in regard to this problem by asking a question such as, "Where do you usually work with him on the mat?" Asked this way the mother has a more difficult time hiding the fact that an intervention has not been practiced. If this particular CM sensed, on the other hand, that the mother was not interested and/or had not performed the intervention, she would ask, "Do you want me to take it back? Do you want to try something else?" That is, she began to see it might be legitimate for a mother not to use an intervention and that it might reflect something about the inadequacy of the task or a failure in the process of matching task to mother's perception of her child's needs. As a strategy, this has the benefit of involving the mother more in helping her child and introduces the possibility of her determining the vehicle and/or even the substance of interventions. While the design and purpose of interventions in NSSI's program has been approached in a variety of ways, and is still in an inconclusive state, the presentation of interventions is one of the areas of greatest duplication of behaviors among Core Mothers and, as such, is one of the clearer aspects of their role. All "model" or perform the intervention task with the target child and then frequently follow this with a request for the mother to do the task. Many use the technique of talking to the mother through the child. The most experienced CMs tend to present the interventions as games which they play, then talk about, including a rationale for the task.

3. The location of work

As has been made clear in various parts of this report, it is rare for any Core Mother-client contact to occur in the program's office. Most contacts occur either in the client's home or in conjunction with medical visits, i.e., offering transportation and/or actually accompanying mother and child inside a clinic, etc. This changes the rules that govern worker-client relations in the expected ways. As one CM says, "I feel being on their turf is a whole different thing and that...I don't feel I should run into the bedroom if the kid is in their bedroom. I would have to ask the parent to go to get him. It's not as easy as being in your (own) home, being in an office or something--you have to respect, you know..." On the other hand, for a family having visits made to their home, while it may offer them convenience, is also more exposing. The gains for the program are greater as they have more access to information on family dynamics and the general environment for the child but at the same time work is subjected to more limitations in that all the distractions of family life can easily invade and intrude on the program's agenda. The quality of interchange is pushed more in the direction of equality as the Core Mother hasn't the formal protective atmosphere of an office. Contacts between NSSI Core Mothers and their clients occur in the following places and ways in descending order of frequency: in homes, at medical facilities, on the telephone, and in public places: parks, restaurants, stores, etc. With much less frequency CMs may engage in either agency-sponsored or client-arranged (and usually social) activities.

The importance of distinguishing the locations of contact was helped by the process of evaluation and again is reflected in the revision of report forms.[1] In general, the new home visit form presently focuses less on interventions and more on the feelings of the Core Mother and her assessment of the interaction between the mother and child and of the presenting family problems without asking that information be limited to specific categories.

On the other hand, the medical contact form makes clear that the requirement for a Core Mother accompanying a mother to a medical appointment is careful observation of the relationship between her and the health provider in specific areas. It asks that rigorous attention be paid to medical information, distinguishing what information has been given to the mother and/or family and what they still need to know, either because it has been withheld, offered but poorly understood, or neither asked for nor offered. In short, location determines the focus of work and may also affect its style to a great extent.

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[1] See Appendix , pg. .

C. The Repercussions of Evaluation for the Administrators

The source of this information is notes taken on ongoing discussions as well as several discussions limited specifically to self-reported effects of evaluation on Administrators between the Administrators and the evaluator. For those who are familiar with the course of the development of new programs, much of the following material will be familiar and redundant.

When the Administrators were asked to summarize what they had learned in the process of evaluation, they listed what could be called the following "understandings."

1. NSSI is a program for caretakers, or mothers, in relation to their children, who comprise the target population, handicapped infants, 0-3 years.
2. Program change is a natural feature of developing programs and is legitimate.
3. Core Mothers are born, not made.
4. Inservice, in general, is a way of intensifying strengths, not eradicating weaknesses.
5. There are overlapping needs and/or experiences of Core Mothers which can be addressed by training.
6. It is important for supervisors and administrators in a new program to have substantial direct first-hand experience with the population served.

Though the first understanding, that the program must work through caretakers to reach children, may seem a rather obvious one, conceptualizing the program in this way reallocates staff time and has the effect of framing and focusing issues differently. The importance of this issue gradually grew in the course of our discussions. When the entire staff began to make observations of home visits, both Core Mothers and Administrators in the observer role tended to report many more behaviors of the client mother even though their "assignment" was to observe the Core Mother. The natural consensus seemed to be that the mothers' behavior was extremely important and the "job" involved attending to and working with that. Core Mothers in their reports of home visits and/or a series of family contacts always talked a great deal about the concerns of the mother and their relationship with her. As this was a common and consistent phenomena across Core Mothers, it became clearer to administration that keeping track of the mothers' behavior and designing ways to attend to the problem of fully "reaching" her were central. Several specific program changes were discussed in relation to this. In revising the home visit form, the problem of how to present interventions was raised--how could a mother's interest be sparked and how could her participation be insured? What language and format should interventions employ? Did a mother prefer to be active with her baby and so on. Accordingly, if the relationship with the mother was crucial to program delivery, attitudes Core Mothers held toward adult women were at least equally important to those they held toward children and needed to be attending to in hiring, training and/or supervision.

The second "understanding," that change is legitimate, is perhaps a corollary of all the others. It was not formerly a conscious part of program functioning to think about what aspects of NSSI's original proposal were undergoing modifications; why, whether they should be abandoned or integrated and for what reasons. Evaluation encouraged this process, but there was reluctance on the part of administration. The changes which were made in the course of program development--in particular, focus on the mother and family--were the predictable result of incoming data.

However, it is our feeling that administration's reluctance to register this in the form of explicit program changes can be attributed far more readily to fear of the consequences of any departure from a proposal where federal money has been received for particular purposes than to merely a general resistance to change. We merely raise the question here as to whether it would be useful for those agencies funding new service programs to emphasize their interest in a process which, in an ongoing way, seeks to integrate incoming information for modifying that service, as well as validating the service as planned.

Report forms are a good example of the formative input of evaluation into program changes. In Appendix D are three report forms. The first, entitled Home Visit Report Form, from the spring of 1978, the second year of program operation, was a revision, but largely a duplication, of several before it. It was developed by Administration and it has three salient features.

1. It determines what categories of information are important by asking few open-ended questions.
2. It devotes over half the record keeping to interventions.
3. It requires Core Mothers to do almost no writing.

There are several assumptions operating here. The first and most important is that the program is fully documented and/or understood and that therefore categories and variables of relevant information can be chosen for systematic record keeping. Second, the proportion of the record devoted to interventions and the title of the form indicates that interventions in the home are the major aspects of the program and its contact with clients. Third, it carries the implication that Core Mothers cannot do too much formulating and/or writing. Fourth, that the information supplied by them will be accurate in spite of all the above.

The second report form,[1] dated Spring 1979, entitled Weekly Contact Report, was devised by Administration, Core Mothers, and the evaluator. It reflects a number of program changes as well as process emphases.

1. It emphasizes contacts rather than home visits. Previously not all contacts were recorded, nor were they viewed as part of the service Core Mothers were offering to families. This not only results in a better record of the circumstances and frequency of program delivery but is a statement to Core Mothers that everything they do with a family is potentially important.
2. Most questions are open-ended. The purpose of these is to allow the Core Mother to express in her own terms her view of the content of the contract. Again, for purposes of documentation, this provides more information about the substance of what is being delivered and for purposes of supervision is more diagnostic of the Core Mothers level of functioning.
3. The form emphasizes the mother as well as the child. This aspect merely reflects the changed concept of the program: that it was expending as many or more resources on caretakers as it was on children.
4. It asks the Core Mother to reflect specifically on her views of what was most important about her work and her own learning. We hoped the effect of this was not only to provide information about program salience and Core Mother progress but to emphasize that the program valued these and Core Mother judgments about them.

The December 1979 form,[2] which is in use at this time, is the result of a staff meeting in which Core Mothers wished to make a new form themselves and suggested all of the revisions. The husband of one of them was enlisted to print it because of the clarity of his handwriting. There are two important as well as interesting changes in the form. It is perhaps most significant that Core Mothers themselves devised the form. In the evaluator's view, this version is the best one because the record form has the full participation and investment of the persons that will be using it. However, there is a second reason it is a useful document. It is because persons who are responsible for the work that is being recorded have the greatest insight into what constitutes the salient aspects of the work.

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[1] See Appendix D , pg. 118.

[2] See Appendix D , pg. 120

This last form presents, or it could be said, insists on two things. The first is that Core Mothers must have a plan when they contact a client; the second is that the program should not only be interested in what it offers to a mother and/or child but should also be carefully noting growth and change in the mother/child relationship.

The third "understanding" for Administrators, that "Core Mothers are born, not made," is a rather startlingly old-fashioned statement, and should be qualified a bit further with "in the light of the amount of supervisory control which this program believes it can and should exert." If we may be further indulged to rely on platitutdes, there also seems to be, on the part of administration, a feeling that if you take the girl out of the country you will take the country out of the girl. Administration assumed that the special worthiness of the program rests on the class match between Core Mothers and their clients and that too much emphasis on technique, interpersonal dynamics, personal development and other such training foci would create a fatal amount of distance between Core Mothers and their clients and ruin their "touch."

Another piece of information that seemed to bring the administrators to the "born not made" conclusion was the qualities which Core Mothers demonstrated, some of which could not be taught, trained, or exacted by any set of rules or principles. The two most experienced Core Mothers were very exceptional people--one, Joan, unusually mothering and nurturant, whose husband, she reports, says about her, "you have an overactive maternity gland," and the second, Ruth, is very giving. No expenditure of energy is too much in the service of a relationship (i.e., she has a woman friend she drives 1½ hours one way to have a cup of coffee with for an hour). We talked with these two women about their patterns of behavior in friendship and in their families in order to try to understand if their relationship with clients bore any similarity or difference and in these two cases there was a great deal of similarity. We feel such a discussion around an application interview could be a helpful diagnostic tool in determining who might be a successful worker with families under stress.

The assumption that paraprofessionals can "naturally" perform some jobs without training is an interesting one which would bear worthwhile study. However, the belief that there is an inherent alignment between program goals and particular women who can be hired to be Core Mothers effectively means that the time, energy and dollars which might be allocated to training in other programs would be allocated to hiring strategies in a program such as this one.

The insight that "Inservice is a way of intensifying strengths rather than eradicating weaknesses" was the result of several pieces of information coming together. In reviewing the past, it was the impression of Administrators that training and supervision had not altered some important qualities of Core Mothers. When they considered the two cases of the only Core Mothers who had resigned from the program, some significant differences between those and the Core Mothers currently employed were clear. Those currently at NSSI were each married and had had extensive work or community volunteer experience. Of the two who had left, both had described difficult relationships with their own mothers and unsatisfactory encounters with institutional representatives about their own children. One asserted that she had never been helped by any agency. Both Core Mothers who left were divorced.

We are fully aware of the potential danger of these observations biasing other programs in favor of hiring paraprofessionals who have intact marriages as workers in high stress situations. We wonder if our few cases may not rather suggest that front line workers in programs dealing with stress need a great deal of reliable support both in the job situation as well as outside of it. While it is clear that there is not necessarily a one-to-one correlation between being married and receiving emotional support, we suspect the quality and quantity of a worker's outside support may be the important addition to insure effective job functioning.

Core Mothers talk a good deal about the effect on them of the amount of stress in some of their client families. For example, the necessity of keeping their caseload balanced between difficult and easier families. Usually this means allotting these descriptive categories 50-50 but occasionally an experienced worker had a higher percentage of "difficult" cases. They report that scheduling the "nice ones" at the end of the day allows them to go home feeling "up," apparently a common practice among Core Mothers.

A second issue inservice had always attempted to address was the multiple complications presented by the issue of handicapping. The original hiring guidelines suggested that another characteristic Core Mothers should possess was to have a handicapped child of their own. The implicit assumption was that therefore issues about handicapping would have been identified, handled, and integrated by these women. Again, the home observations during evaluation uncovered some areas previously unmonitored and relatively untouched by training. They were:

> How does the Core Mother assess the clarity with which the family understands the child's problem and how does she deal with this as a result?

> What is the Core Mother's definition of success and failure in learning?
>
> How aware are Core Mothers and program staff of their own feelings about handicaps?

Taking the last first, a wide range of tolerance toward and understanding of any human phenomenon involving damage or deficit is displayed among this staff as it would be in any other, in spite of their own experience with handicaps. The basic question handicapping presents is "how much should the client know?" For instance, when reports of home assessments were given to parents, developmental ages were rarely reported if they were far below the actual age of the child. The ethics of this decision had not been discussed among staff nor had any decision ever been made about how to handle this issue.

The fifth insight is that "there are overlapping needs and/or experiences of Core Mothers which can be addressed by training." In the case of any new program, it takes time to discover what its real purposes can be and what its real limitations are, as compared to those that were planned and predicted for it before its population collided with its proposed services. NSSI, after three and a half years, is not in a position to better understand the assets and deficits of its workers, the scope of the program and the needs of its clients. As is all too clear by this page of the report, the families' needs were not limited to their handicapped infants but spread into many areas. Both the Core Mothers and the Administrators responded to this on an intuitive basis by focusing on other problems as well as the child's handicap. NSSI, in considering the lessons their program offers to new ones, suggests that a program with child progress as its focus requires a broader response to the family and environment in order to achieve progress with the target child. The training issues raised by current program functioning can be divided into those that address the specific interaction with the target child and issues that go beyond this. Specifically with regard to interventions, they cover:

1. The Design of Interventions

   What are the range of goals that are appropriate for interventions? (Remediating practice for physically handicapped child to encouraging interaction between mother and child.)

   What are the materials that can be used?

   What possible uses of these materials can there be outside of the intervention?

   Who is the subject of the interventions and why?

2. How to Present Interventions

   What strategies can be used? (Modelling, telling, reading, demonstrating without the child.) What are their advantages and disadvantages in general? with specific families?

Who should be involved and why? The caretaker (mother, father, day care mother), other family members?

Common Handicaps

What are the most common handicaps and what are their attendant physical and psychological complications?

How to Talk to Doctors

Obtaining information; how to ask, who to ask.

How to identify what information you are not receiving (consultation, medical resources).

As for the sixth and last outcome of the evaluation for Administrators, it was the bias of the evaluator that Administration should participate in service and her express intention to support and encourage them to do so. One clear reason for this is the credibility it lends supervisory staff to have done or be doing similar work to those who are engaged in front line service. In a new program it is doubtful that administrators will have had past experience with all program elements. NSSI was working with a largely uninvestigated population and set of experiences--the at-home life of handicapped very young children and their families. As it turned out, many families were also poor and/or disorganized. In addition, as we have said, many times previously in this report, the nature of the service to be delivered and to what extent it could be confined to a few areas, either in terms of the families' needs or the workers' abilities, was unknown. The real life pressures and dialy existence of these families needed both extensive exploration and reflection for intelligent decisions to be made about the nature of the services which would be suitable, the form of their delivery, and the characteristics of personnel who might be most successful. It was the evaluators' feeling that gleaning this only from the reports of front line workers was perhaps limiting to its true topography and time consuming as well. It was the program change which has the lengthiest incubation period, but from the evaluator's view was the most important and gratifying to have achieved.

SUMMARY

A close reader of this report will have noticed that several pieces which we had anticipated completing and which relate to replication of this project are not included. We have not developed nor can we deliver at this point a satisfactory curriculum for training Core Mothers. We have concluded instead that attention to hiring and supervising workers is more practical than the development of a standard preservice or inservice curriculum. We are increasingly confident at identifying those experienced mothers who have learned to tolerate ambiguity and uncertainty, who are empathetic but who suggest they can maintain some distance from clients. We seek candidates whose enthusiasm allows them to accept dependent relationships but who value and support families' independence. We hire women who can describe responding differently to their own children's individual needs and who understand that parents as well as children may be at different points on a developmental continuum.

The basic skills that we nurture in Core Mothers help them gather and report information relevant to their work with individual families. By careful observation and questionning workers assess what a client needs, learn what a health provider thinks about a child and see how a child responds to new exerçises. Formulating effective questions requires confidence, persistence, and willingness to risk exposing what is unfamiliar. Since questions to clients may be threatening, workers must time their inquiries carefully. Through written and oral reports Core Mothers inform NSSI administrative staff about changes in the lives of their clients so that they can discuss their program together.

Core Mothers were hired to support client families as peers but initially some families seemed surprisingly unfamiliar to them. With experience, NSSI workers have learned to distinguish crises from unusual behavior that is characteristic of an individual's lifestyle. Since this is uncharted territory with few sure guideposts, Core Mothers need access to all NSSI staff when one of "their families" is under particular stress although one administrative staff person is identified as the Case Manager and is responsible for supervising the Core Mother's work with the family. We had not anticipated how often legnthy discussion would precede NSSI intervention and unfortunately we are not able to document how much staff have learned through such discussion about infants, family and intervention but we are persuaded that federal funds have supported as much change in staff knowledge as in child progress. More often learning occurred in the context of work with particular families than in planned inservice training.

Although differences exist between Core Mothers and clients, most families are particularly receptive to non-professional home visitors and Core Mothers seem both more willing and more able to become profitably involved with a variety of problems in a family than home visitors who are professionally credentialled. Our impression is that training and credentialling lead to a more circumscribed role although we are aware that anyone working in clients' homes may function more flexibly and informally than they would in a clinical setting. Until other investigators are able to observe and compare professional and non-professional staff as home visitors our impressions remain informed hunches. It would also be useful to learn about families who wanted professionals as home visitors as to whether their inclination reflected the educational background of the adults or the provisional diagnoses given to the child.

We have described how NSSI's responsiveness to community institutions effected the character of our caseload. With a different staffing pattern including more workers with professional training as special educators or therapists we might not have been so open to families whose young children were at high risk for delayed development because of their environment. Although working only with families who are chronically overwhelmed would be unsatisfactory for a Core Mother, it has been worthwhile for NSSI to include some families in which children are understimulated and some who have been identified as at risk of abuse or neglect. Since the goals of early intervention should be preventive as well as remedial, we assume that BEH will continue to support models that demonstrate delivery of services to infants and toddlers who are at risk of handicapping conditions as well as those who are certifiably handicapped. Our experience suggests that while clinicians are sometimes reluctant to identify disability and predict delay, the risks of withholding intervention are substantial and the potential impact of increasing positive interaction between mother and child is great.

Although we support early intervention programs enrolling infants who are not yet at established risk we are aware that limited resources support services for children under three and we know also that an individualized focus limits workers to a small caseload. Consequently we have had to set priorities and, occasionally defer referrals to a waiting list. Balancing the concern of the referring source, the apparent needs of the child, and the expressed interest of the parent, we assess how appropriate the family is for NSSI. The parent's motivation to accept intervention influences our decision since our experience with families whose referral to NSSI is court mandated or based entirely on another provider's assessment has not been encouraging. We hope that by keeping the criteria that mandate involvement general we lessen the likelihood that a potential client will feel stigmatized by a referral to our program.

Data from our evaluation suggests that the relationship Core Mothers establish with their clients has more characteristics of a friendship than of a client-worker alliance. The Core Mother is seen as reliable, responsive, supportive and sensitive even though the relationship is not reciprocal and most often is not maintained after NSSI terminates. Because the role is new and flexible and perhaps also because the whole program is small, Core Mothers are experienced first as individual women whose assistance is practical and whose concern is genuine.

Clearly the outcomes of this kind of support are hard to measure. In the evaluation section the impediments to summative assessment are detailed so here we want to summarize the gains from the evaluation we did undertake and suggest that for a program like NSSI child progress data may not be the relevant index of program effectiveness. Not only are the instruments problematic but developmental change is particularly rapid and vulnerable to so many other influences that assuming progress to be a consequence of program participation is simply presumptuous. The educative perspective of our evaluator meant that she encouraged staff to accept NSSI's flexability as an appropriate function of its youth and its services and, furthermore, as an asset in the work of reviewing what existed in order to define the limits of the program's responsiveness. The process by which staff articulated their assumptions about all elements of NSSI's operation in the context of discussions about individual home visits had significant implications. Certainly we expected that individual interpretations of the role of the Core Mother would be exposed but in addition administrative staff exposed their lack of familiarity with many details of home visiting. Our impression is that in spite of some concern about lack of time and focus, all participants felt they learned information that was only accessible through discussion. Although new home visit forms,which were an unintended outcome of the evaluation, improved reporting about individual families, staff discussion continues to be the legitimate way to consider general questions that affect program development. Administrative staff and Core Mothers work more openly together as a result of these discussions, the developement of the Case Manager role and because administrative staff have each assumed direct service responsibility for a few families.

Staff attitudes toward evaluation have changed and if our federal funding had continued we would have gathered more data about program impact. Specifically, we would have interviewed selected client parents and we would have tried to differentiate NSSI's impact on parents and children from those of the other early intervention programs in our area. We might have pursued an intriguing recommendation to examine changes in staff attitudes toward their own children. Scrutinizing what NSSI provides to families with handicapped children under three has raised many questions about education, relationships and intervention and it has generated commitment to change as a consequence of innovation and to support for the continuation of NSSI's services.

VIII Appendix

EMILY D: A CASE STUDY OF NSSI INTERVENTION

1. Initial Referral

In December of 1977, Mrs. D. called the NSSI office to refer her daughter Emily. Mrs. D. stated that Emily had her first birthday in November, that she was quite small and slow for her age. She had been born prematurely due to placenta previa.

2. Family History and Initial Developmental Evaluation

Marti, an occupational therapist, and Sheila, an early-childhood specialist, planned to begin a developmental evaluation on this initial visit. Mrs. D. was waiting for them in her two-family house in a well-kept neighborhood. She looked older than her 43 years, and she had a prominent scar accross her face. Emily was lying on her back in a playpen, surrounded by toys, but did not alert or respond to the strangers entering the room. She rolled her head rhythmically, and did not look at the objects or people near her.

Mrs. D. answered questions about Emily and the family only briefly and asked few questions herself. She and her husband, George, 46, had grown up in Somerville. They each came from large families. Mr. D. has worked as a trucker for 17 years. Their eight other children, ranging in age from 20 to 2, live at home. Mrs. D's parents live in the first floor apartment and are in their 60's.

Mrs. D. described her pregnancy with Emily as initally not different from her others. She gained only eight pounds and had a fall in the fifth month requiring an x-ray of her knee. At seven months however, she began to have some bleeding and an ultrasound revealed placenta previa. Emily was delivered by Caesarian section, six weeks prematurely, weighing 2 lb. 2 oz. She was transferred to Children's Hospital because of breathing difficulty. She required a transfusion because of jaundice and remained in the hospital for one month when her weight reached 4 lbs. 8 oz. Mrs. D. thought Emily was an "easy" baby because she preferred to be in her crib, away from the commotion of their large family. Dr. Z. the family's pediatrician, had warned her that premature babies are often slower, so she had not become concerned about Emily's development until she refused all but one bottle and had to be forced to accept strained baby food. She accepted only bland ceral and potatoes. Mealtime had become a battleground.

Her discussions with Dr. Z. led to a referral to Dr. J., a neurologust at Kennedy Memorial Hospital. After a brief examination, Dr. J. told Mr. and Mrs. D. that at 12 months Emily was behaving like a 2 month old. Perhaps she had some hearing loss. He was not inclined to do a full workup immediately, but preferred to see Emily in six months, as she "might catch up." He recommended finding an infant stimulation program for Emily; Mrs. D., through the social services department referral, sought out NSSI.

Marti evaluated Emily using the Bayley Scales of Infant Development and the Sewell Early Education Development Evaluation (SEED). Emily was quite small for her age, 13 lbs. Her eyes were large and deeply set, with a prominent forehead and low-set, elf-like ears. She protested being picked up and threw herself backward when placed in sitting. On her stomach she lifted her head for a moment, then rolled on to her back. When left alone, she watched the writhing movements of her hands or kicked her feet. Emily withdrew her hands when presented with toys but would contact an even search them out with her feet. Emily laughed and patted Marti's throat, when Marti made a vibration sound. Emily appeared to be delayed in all areas of development and most of her behavior was directed toward shutting out stimuli. Emily's willingness to contact toys only with her feet, difficulties her mother described with feeding, dressing and bathing, and her acceptance of vibration suggested that she was especially sensitive to tactile stimuli.

Marti remarked that Emily seemed especially sensitive to touch and Mrs. D. agreed, adding that had she only recently been able to cuddle or rock Emily when whe was distressed. As Emily fell asleep in her lap, Mrs. D. agreed to participate in the program and learned that a visit by the Core Mother, Coreen, the nurse practitioner, Donna, and the physical therapist, Jodie, would complete the initial evaluation.

During this evaluation process, it became clear to NSSI staff that beginning a stimulation program without adequate medical/niurological investigation had serious drawbacks. First, we wanted to be sure that Emily did not have a treatable disorder, e.g. a metabolic problem. Second, we wanted to be aware of any contra-indications to stimulation, e.g. cardiac status; and third, without clear, non-ambiguous information to the family, we doubted the effectiveness of the intervention program. Despite our concern, NSSI was unsuccessful in convincing Dr. Z. to order a full workup. Mrs. D. deferred this decision to him and would not make an independent referral. Dr. Z. felt that it was " a waste of money" to find out that Emily had "a syndrome," and told us that if the D's heard a diagnosis of retardation, they would neglect her. He agreed that Emily was seriously delayed, but believed that at least in part, the delay was due to lack of stimulation. He based his opinion on the fact that Emily came in for check-ups with her aunt or father, rather than her mother.

3. The First Individual Program Plan, January, 1978

As a result of our inability to secure the cooperation of Emily's pediatrician, the first Individual Program Plan (IPP) reflected a more tenative, "information gathering" type of approach. We agreed that Emily was a complicated child, requiring long-term observation and that our relationship to Mrs. D. would be complicated as well. Emily appeared to be significantly delayed, at the 3 1/2 - 4 1/2 month level, and she generally withdrew from most changes in her environment, into crying, sleep, or self-stimulation. There was a great deal of concern about Emily's weight, 13 lbs. at 14 months, and her ongoing feeding problems. Emily would only take one bottle in the morning, and resisted most spoon feeding during the day. Mrs. D. was shy and reticent about discussing how Emily's problem affected her family or herself. Although she agreed verbally to try out suggestions, she never became animated or asked questions. This situation was aggravated by the fact that one of Mrs. D.'s eyes turned in, giving the impression that she was not making eye contact. It was predicted that forming a relationship might be difficult especially under the circumstances of an unclear diagnosis. We planned to introduce other possible sources of support, i.e., Headstart, Supplemental Security Income (SSI), and respite provided by the Core Mother because referring families "to" community services tends to increase the chance of engaging them in the relationship with NSSI. Second, we requested all pertinent medical records and in turn sent our evaluations and recommendations to Dr. Z., in hopes of gaining some cooperation from him. Third, we planned a short-term period of observation of Emily's response to different types of stimulation. This required Marti to work closely with Coreen, andthe Core Mother, both in planning interventions and observing their effects on Emily's ability to organize herself and explore the environment.

Coreen began regular, weekly home visiting in January, 1978, bringing several interventions to each visit. They emphasized sensory stimulation, especially deep-pressure to Emily's hands, movement stimulation and vibration. Activities were also designed to increase head control and reaching for objects. Mrs. D. reported that although she often didn't have time, her other children carried out the interventions. Coreen felt frustrated, first by feeling that Emily's mother was not as involved with Emily as she should be, and secondly by her feelings of "failure" to reach Emily who fussed, cried, or slept through most of her visits. In supervision we discussed how Coreen's reaction to Emily's negative feedback may in fact mirror Mrs. D's experiences. With some understanding of how difficult it must be to "mother" and play with an infant who is "rejecting," Coreen was able to be more sympathetic. After several months, Mrs. D. began taking pictures of Emily doing the interventions successfully, and she reported that it usually took Emily several days to try anything new. She seemed to be trying to protect the Core Mother from feelings of frustration with Emily's apparent lack of responsiveness. Coreen also encouraged Mrs. D. to accompany Emily to her next checkup with Dr. Z. In March, she did so and reported that Dr. Z. was pleased with Emily's progress developmentally, but concerned about her weight. The doctor recommended a regimen of chocolate bars. As Emily would not eat solid foods, finger feed, or eat anything new at that time, it was an impossible plan to carry out.

4. The Second Evaluation and the Second IPP, April, 1978

The NSSI re-evaluation in mid-April showed that Emily had made some progress. She was now sitting, reaching and transferring objects. She laughed when swung or tickled and responded to her name. Emily continued to retreat into self-stimulation, cry, or fall asleep when given new activities or toys.

The second IPP included specific developmental goals in all areas, because we felt more comfortable about our understanding of Emily's patterns of development, and because the home visits needed the structure that these kinds of objectives provide. The second area of focus was on the family's awareness of Emily's special needs. Although there had been some improvement in the rapport between Coreen and Mrs. D., especially since Dr. Z. noted Emily's progress, Coreen felt especially uncomfortable about the unspoken issues of Emily's diagnosis and future. In order to support Coreen in this objective, a parent meeting was planned with Mrs. D. and Marti, Coreen , Sheila and Donna, to discuss the recent NSSI evaluation and to get her feedback about the program. Mrs. D. told the staff that she felt the interventions had helped Emily progress and that she especially liked them because they were not things she would have thought of herself. However, she added that she found it hard to do many of them because Emily cried. Frequently her other children would complete the interventions. Although Mrs. D. did not use this meeting to share her concerns about retardation, at Coreen's next home visit Mrs. D. remarked that "Emily's brain was slow." Mrs. D. finally seemed to be opening up. It may be difficult for a Core Mother to confront uncomfortable issues when she has a peer relationship with her client, and we have found that occasional family-staff meetings lead to more open discussion.

In May, Coreen accompanied Mrs. D. and Emily, now 18 months old, to a checkup with Dr. Z. He found that she had lost 6 oz., weighed only 13.33 lbs., and was anemic, and scheduled an admission to the Boston Children's Hospital Medical Center for a failure-to-thrive workup (full range screening, blood work, TORCH titers, CAT scan, EEG, sweat and chromosomal testing). All tests proved negative. Evaluation of Emily's behavior indicated a 5-6 month motor development and 6-12 month cognitive development, a gain of 2-6 months. Nursing staff and members of the feeding clinic found that feeding Emily was difficult. She seemed to become full very quickly, and then locked her mouth shut, or vomited if pushed to eat more. Hospital notes indicate that although Mrs. D. visited only occasionally, she interacted warmly and appropriately with Emily. Discharge diagnosis was failure to thrive of uncertain etiology; delayed motor and cognitive development. A referral was made to the Developmental Evaluation Clinic at Children's Hospital for follow - up.

Dr. Z. contacted the NSSI nurse practitioner to discuss the hospitalization and lack of clear findings. He offered to share any new findings and supported the NSSI home program. He asked that the home visits be increased to twice a week. He and Mrs. D. decided that the Developmental Evaluation Clinic and physical therapy at Children's Hospital would be repetitive of NSSI interventions. Several home visits after the hospitalization, Mrs. D. shared her frustration about the hospitalization with the Core Mother. She felt she had been kept for a long time answering questions and had been given little infromation. She felt compelled to "stuff" food into Emily, so she would gain weight.

5. The Summer Program - A Turning Point?

Mrs. D's commitment to NSSI's program grew during the summer of 1978, despite a change in home visitors. Ruth the new Core Mother, and Marti, each visited once a week and remarked to each other how changed Mrs. D. seemed. She was more involved, asking more questions, beginning each visit with photos or descriptions of Emily's progress. Soon she began to modify interventions and generalize their concepts into her own activities, demonstrating them herself with Emily on the floor. Emily was outgrowing her clothes and responding with lots more eye-contact and smiling.

Marti visited weekly, providing a sensori-motor program of deep pressure and fast-vestibular stimulation, followed by adaptive motor activities. Marti especially wanted to respond to Mrs. D's reaction to Emily's crying during interventions. She allowed Mrs. D. to comfort Emily whenever she cried during treatment, increasing the opportunities Mrs. D. had to successfully soothe Emily. Together they worked on "reading" Emily's cries, and on increasing reaching out and eye contact during fussing. Mrs. D. was delighted when Emily finally turned, reached out her arms and looked into her face, "asking" to be picked up and soothed.

Ruth then visited later in the week and had Mrs. D. show her what she had been doing. Ruth was vigorously affectionate with Emily and became an ally of Mrs. D. very quickly. Ruth discovered that, until Emily was hospitalized, Mrs. D. had never had more than an hour or two away from Emily. Although Mrs. D. believed that Emily would cry the whole time, she reluctantly agreed to allow Ruth to take Emily for several hours each week. Despite the fact that Emily's grandmother lived in the same house, she had never been able to feed her, so she was unable to take Emily for very long. Mrs. D. was able to go away to a friend's wedding and even brought her to Maine to see her other grandparents for the first time, because she had evidence that Emily could finally handle new situations and different caretakers.

6. The Third Evaluation; Plans for an Infant Group, September, 1978

Changes were apparent in Emily's development in her re-evaluation in September. Progress was especially observed in the social-emotional area. Emily would now consistently turn and reach out to her mother when she needed comfort or help. She made apporpriate eye contact. She tolerated a greater variety of toys and she could switch from one to another she could imitate simple actions such as banging and squeezing. Mrs. D. was also more confident in her interpretation and handling of Emily's behavior. A well-baby visit to Dr. Z. at summer's end confirmed NSSI's view of Emily's progress. The nurse practitioner from Dr. Z's office called to share her pleasure in Emily's development - Emily had gained four pounds, and the nurse agreed to pursue a PKU screening and vision test, recommended by Marti.

In September , Emily began attending an infant group at the Cambridge - Somerville Mental Health and Retardation Center's Pre-School Unit, was Mrs. D. had rejected this notion in the spring, only to change her mind after speaking to a friend with a retarded daughter. Marti accompanied Emily for several of the first sessions, demonstrating sensori-motor techniques and acquainting Emily and the teachers. Emily settled in well with the routine, and blossomed again when she got her glasses in November. She tolerated them well, and took particular pleasure in watching herself in the large mirror on the wall of the classroom. She also began to watch other children more intently.

Mrs. D. also enrolled Emily in the NSSI infant swim program held at the local "Y". She came with her oldest sister and became the "star" of the group, laughing, bubbling, and exploring the water. Mrs. D. remarked that now bathtime was her favorite and most frequent activity with Emily, as she seems the most "normal" then. Mrs. D. remark reinforced our earliest concept of intervention, that we needed to reduce Emily's negative affect in order to increase mother-infant stimulation.

One year later, at 32 months, Emily continues to make steady progress. Presently she walks independently and crawls up stairs, babbles, empties containers, and will finger feed and use a cup. She rarely falls asleep or tantrums when in a new situation, but instead looks at the adult angrily. She understands simple gestures, but uses none at this time.

Mrs. D. makes use of services more readily. She requests respite when needed and enrolled Emily in a summer program at the Pre-School Unit. She has discussed the future in terms of Emily's delay and is aware that Emily will probably never be independent. Mrs. D. and the Core Mother initiated an evaluation at the Department of Mental Health's Community Evaluation and Rehabilitation Center (CERC). As a result of this evaluation, Emily will be receiving twice weekly treatment by an occupational therapist in addition to her program at the Pre-School Unit.

Discussion

Perhaps the most important role NSSI served was as advocate for the D. Family in obtaining adequate medical diagnostic services. Because of the D's total faith in their pediatrician, coupled with his apparent misreading of Mrs. D's style, Emily's problems were largely ignored. NSSI intervened at this point, encouraging Mrs. D. to meet with Dr. Z. herself. Perhaps her increased interest prodded Dr. Z. into ordering a full evaluation, which subsequently underlined the need for treatment.

NSSI helped Mrs. D. understand the tests and interviews that were done at Children's Hospital. Until the results in the records were shared with her, Mrs. D. believed that she was largely responsible for Emily's problems. Neither the hospitals, nor Dr. Z. had explained to her that the lack of positive medical findings did not mean that there was no organic reason for the delay. She was greatly relieved to hear that the hospital had believed her to be a "good mother".

NSSI provided individualized, developmental services. Emily, and infants like her, rarely follow expected patterns of response. Without home visiting and weekly monitoring of the effects of activities, appropriate treatment would have been impossible. The CERC team corroborated this view, stating that if Emily had begun in a center based program, she might now be more withdrawn and delayed.

Finally, the NSSI Core Mother served as a listener for Mrs. D. Mrs. D. felt that since she had wanted this baby, she was totally her responsibility. Despite her large family, she was unable to share the physical care or discuss the concerns about Emily with them. She protected herself and Emily from negative or embarrassing situations by withdrawing. When the Core Mother took such an obvious caring role with Emily, Mrs. D. was able to relinquish some of the responsibilities and worries to both her family and professionals. It is tempting to speculate that if a professional had worked successfully with Emily at first, the mother-infant bond might have been further weakened. We have been impressed by Mrs. D's growing ability to ask questions and act in her daughter's behalf, and we believe that the Core Mother, as a peer-helper, fostered those strengths.

Individual Program Plan #1 from 12-19-77 to 2-19-78

Name: Emily
Date of Birth: 10-10-76
Age: 14 months, 9 days
Core Mother: Coreen

Precautions: Be wary of effects of stimulation. Avoid overloading(she might cry, pull back, speed up, react negatively, ½ hour after stimulation).

Present Functioning:

Emily explores objects with her feet and shows an understanding of cause and effect in the way she repeats actions with toys. She visually follows, reaches using one hand, and holds toys briefly. Emily localizes sounds and vocalizes pleasure and displeasure. **Emily** moves on her back, rolls in her play pen, and sits supported in a chair with sides.

Areas to reinforce: Mother's low-key patient style seems very appropriate with Emily. Support emerging social skills.

Goals and Objectives:

Goal 1: Coordinate medical and developmental services.
Sent - Objective 1.1: Send for records from Dr. Zisskind, Dr. Joseph, from Kennedy audiological. Rec'd
Objective 1.2: Secure Jodie's PT evaluation and recommendations.
[illegible] - Objective 1.3: S.S.I.? Headstart? Coreen will call for applications.
[illegible] Objective 1.4: Evaluate family's need for respite, transportation. [illegible]

Goal 2: Evaluate effects of specific sensory stimulation. [illegible]
Objective 2.1: We will know which stimuli (i.e. vibration, movement, temperature, deep pressure, etc) has the effect of increasing exploration,
a. manual b. mobility
Objective 2.2: We will set SEED goals in 2 months. [illegible], 4 mo.
Objective 2.3: We will have complete evaluation of ADL(dressing, bathing, feeding, sleeping) within 2 months.

Individual Program Plan #2 From 4/12/78 to8/12/78

Name: Emily
Date of Birth: 10/10/76
Age: 18 months 2 days
Core Mother: Coreen

Precautions: Overstimulation/understimulation

Present Functioning:

Emily is now sitting with good enough balance to reach forward. She reaches readily with either hand and transfers to explore objects. Emily can hold two objects for a long time. She has some awareness of how things work-she shakes a rattle and looks for a dropped toy. Emily laughs when moved or stimulated by touch. She responds to a pick-up gesture, enjoys patty-cake and stops her activity when her name is called.

Goals and Objectives:

Goal 1: Coordinate medical and developmental services.
- Obj. 1.1: Send written request to Dr. Ziskind for well-child medical records.
- ✓ Obj. 1.2: Consult with Jodie Kiser re: developmental questions.
- Obj. 1.3: Send written evaluation reports to Dr. Joseph before Emily May visit.

Goal 2: Support mother's awareness of Emily's special needs.
- ✓ Obj. 2.1: Mother will ask one question about each intervention ...
- ✓ Obj. 2.2: will encourage mother to take Emily to May visit to Dr. Joseph.
- ✓ Obj. 2.3: Family meeting with mother will happen in early May.

Goal 3: Increase Gross motor functioning. Emily will:
- ✓ Obj. 3.1: get to a crawl position:with stomach on floor, lifts chest and brings one knee forward. c̄ support
- ✓ Obj. 3.2: support entire body weight on feet briefly, when held by hands in standing position.

Goal 4: increase fine motor/adaptive functioning. Emily will:
- ✓ -- Obj. 4.1: begin to grasp one block with tips of thumb and first and second fingers.
- — Obj. 4.2: successfully pick up pellet: between thumb and side of curled index finger, other fingers do not curl.
- ✓ Obj. 4.3: deliberately but awkwardly let go of one block.
- ✓ Obj. 4.4: watch toy being hidden under cloth and uncover toy.
- ✓ - Obj. 4.5: bring blocks together, one block in each hand, with or without banging.
- ✓ Obj. 4.6: touch a block dropped in cup by examiner.
- ✓ Obj. 4.7: grasp bell by the handle and ring purposefully.

Goal 5: Increase Social/Emotional functioning. Emily will:
- ✓ Obj. 5.1: initiate contact with adult by smiling or making sounds.
- ✓ Obj. 5.2: reflect facial expression of adult; mimic.

Goal 6: Increase Language functioning. Emily will:
- ✓ Obj. respond with the correct gesture to words like [✓ up] bye.
- ✓ Obj. 6.2: use sounds other than crying to express feelings of pleasure and displeasure.
- ✓ Obj. 6.3: initiate making sounds directly at people.

IPP #3 9-15-78 to 1-15-79

Dion, Emilv
DOB: 10-10-76
Age: 23 months, 5 days
Core Mother: Ruth
Case Manager: Marti

Precautions: Overstimulation/understimulation: avoid light touch and "gentle" handling; use quiet, rhythmic sounds. Help Emily get used to unfamiliar objects and experiences through repetition.

Present Functioning: Emily is beginning to pull to a standing position and cruise on the couch or playpen. She changes directions, negotiates corners, and steps over obstacles (in a familiar place). She can get on her hands and knees with assistance and tolerates this handling. Emily holds and explores a variety of objects with her fingers. She enjoys objects that she can spin, bang and shake and can imitate a simple action on an object. She plays patty cake and makes eye contact during "games." She seeks eye contact with her mother and gestures to be picked up. Emily now holds her own bottle, brings an empty cup to her mouth and will occasionally tolerate lumpy foods.

Goals and Objectives

Goal 1: Coordinate medical and educational resources

✓1.1 Pursue PKU screening (Marti)
✓1.2 Send current IPP with cover letter to Dr. Ziskind, Pre-School (Marti)
✓1.3 Determine appropriateness of following through with DEC referral made in 5-78 (Dr. Margaret Siber X2101)
✓1.4 Evaluate pre-school placement in 4 months.

Goal 2: Family Support

✓2.1 Mother will attend Pre-school Mother's group
2.2 Find ways for Mrs. D[illegible]r to share her ideas about handling Emily with NSSI/other parents, i.e., ✓taking pictures of successful activities, keeping a list of Emily's favorite games, sharing feeding techniques with another parent.
2.3 Familiarize Emily with other care-takers.
    2.31 **Emily** will have 1 or more available people with whom she can stay for 2-3 hours.

Goal 3: Gross Motor Emily will :

✓3.1 pull self up to knees, pulling on furniture
✓3.2 go easily from sitting to creeping and back to sitting
R 3.3 sit, move in a circular manner, swing around on buttocks

Goal 4: Fine Motor/ Adaptive Emily will:

(L)✓4.1 grasp one block with tips of thumb and first and second fingers(radial digital grasp)
✓4.2 reach for pellet; index finger straightens(con't p. 2)

✓4.2 pick up pellet between thumb and tip of index (or middle)finger, hand rests on table (inferior pincer prehension)
✓4.3 ring and string on table; pick up string with fingers .
—4.4 with demonstration: release block into cup R into jug
—4.5 with demonstration: try to stack blocks
✓4.6 with or without demonstration independently dangle ring by holding string
4.7 with demonstration: try to insert pellet into bottle

Goal 5: Social/Emotional Emily will:

✓5.1 show off, repeats performance if laughed at
—5.2 give toy to examiner spontaneously
—5.3 wave bye-bye

Goal 6: Language Fmily will:

✓6.1 stop her activity when she hears "no" (100% of the time)
✓6.2 look at simple pictures for 1 minute, if they are named
✓6.3 says "Mama," "Dada"(without specific meaning)

Goal 7: Self-Help Skills Emily will:

✓7.1 mouth objects - brings to lips
—7.2 bite a cookie — licks salt from cracker
7.3 be in a sitting position for dressing

Goal 8.
stimulation w/ diffrent materials
masking tape
rough face cloth
green grass mat
smooth styrofoam
ice pack
not a Goal — Intervention

IPP #1 10-31-78 to 2-31-79

Bonnie
DOB: 5-2-78
Age: 5 months
Core Mother: Jean
Case Manager: Donna Karl

Present Functioning: Bonnie follows a rattle in a 180 degree arc as it is rattled. She turns her head to the sound of a bell or rattle. She reaches toward a rattle and holds it briefly when placed in her hand. She brings her hands together at midline.

Bonnie prefers lying on her stomach according to her mother's report, and is able to lift herself onto her hands. She turns from stomach to back. In her infant seat she makes an effort to sit and when pulled to sit keeps her head in line with her back.

Bonnie smiles at herself in the mirror. She makes sounds in response to being talked to and squeals to show pleasure. She watches her mother across the room.

Goals and Objectives :

1. Increase mother's confidence in caring for Bonnie
    1.1 Jean will assist Judy in bathing Bonnie. ō done yet.
    1.2 Jean will suggest ways of playing with Bonnie when she's out of the infant seat. + put in high chair / on floor. Encouraged Judy to get play pen - which she has.

2. Insure nutritional needs.
    2.1 Donna will send for appropriate health records. yes
    2.2 Encourage iron intake in diet. ? Encouraged Solids
    2.3 Jean will work with Judy on Bonnie's calorie intake. +

3. Fine Motor/ Adaptive--maintain developemntal progress
    3.1 Bonnie will begin to reach for objects with one hand at a time. yes
    3.2 " " hold rattle for a long time. +
    3.3 " " pick up one or more blocks, when one is placed in each hand and hold them more than momentarily. — picks up 1 block
    3.4 " " attempt to pick up a pellet. +
    3.5 " " transfer objects from hand to hand. +

4. Social- Emotional --maintain developmental progress
    4.1 Bonnie will reach and pat mirror image. +
    4.2 " " enjoy frolic play. +

5. Gross Motor
    5.1 Bonnie will sit steady on firm surface 10 minutes unsupported. +
    5.2 " " push body up to knee-hand position. + crawling

6. Speech and Language
    6.1 Bonnie will respond with correct gestures to words like "up," "bye-bye." + ?
    6.2 " " play pat-a-cake and peek-a-boo with or without speech. +

IPP #2 2-26-79 to
6-26-79

Bonnie
DOB: 5-2-78
Core Mother: Jean
Age: 9 months 24 days
Case Manager: Donna Karl

Present Functioning: Bonnie is responsive to people. She smiles often and laughs aloud when rough housing. She loves peek-a-boo and prolongs it by showing her pleasure and carefully watching for the appearing face. She squeals, grunts, and her mother reports she says "dada" and "meme".

Bonnie is beginning to drop objects on purpose and look for a fallen spoon. She reaches for and grasps a block with each hand bringing it to her mouth and transferring from one hand to the other.

Bonnie crawls on hands and knees and gets from crawl to sitting position easily. She supports her full body weight in standing and prefers an upright position to lying down. She is beginning to finger feed soft foods and tolerates them very well, according to her mother though she still primarily eats strained baby foods.

Judy, her mother, was present throughout the evaluation and offered a great deal of information , demonstrating her awareness of Bonnie's activity, likes and dislikes.

Areas to Reinforce: Bring to Judy's attention the ways she's doing a good job with Bonnie.

Goals and Objectives

1. Maintain contact with other agencies
    1.1 Jean will go with Judy to meet Bonnie's day care mother and bring a copy of the IPP to her. +
    1.2 Donna will send evaluation report and copy of IPP to Mary Ann Lewis and call her as needed. +
    1.3 Jean will go to court with Judy and Doug on March 16. +
    1.4 Donna will call Sherri Mallory about the Tufts Medical Center group which is working with the family. +
2. Support mother's enjoyment of Bonnie
    2.1 Jean will suggest ways Judy can enjoy holding Bonnie +
    2.2 Jean will bring activities to help Bonnie "talk" more to her mother. +
3. Plan for Bonnie's getting outside with good weather
    3.1 Jean and Judy will plan ways for Judy to get out of the house with Bonnie + Judy bought a carriage & took Bonnie out a couple of times before the weather was better,
4. Maintain developmental progress in feeding; Bonnie will:
    4.1 finger feed herself 2 meals a day –
    4.2 be off of commercial strained baby foods + has course blended table food
    4.3 be weaned from the bottle +
    4.4 drink from a cup at each meal + w/ help most of time
5. Fine Motor/Adaptive Bonnie will:
    5.1 play with blocks (drop one, pick up another) +
    5.2 remove round shape, look at round hole +
    5.3 with demonstration, put round shape into board + w/c demo
    5.4 pick up pellet between thumb and tip of index or middle finger; hand held slightly above table (neat pincer prehension) +
    5.5 release one block into a cup + releases 2

Bonnie Burpee (con't)

6. Gross Motor Bonnie will:
    6.1 holding furniture for support, walk sideways by moving hands and feet +
    6.2 stand alone momentarily, no support + Ⓡ ct me, while Bonnie is at couch.
    6.3 walk forward with one hand held —
    6.4 walk few steps alone (13 months) –
7. Social/ Emotional Bonnie will:
    7.1 wave bye-bye appropriately without imitation +
    7.2 squeak doll imitatively +
    7.3 enjoy putting in and taking out games +
8. Speech and Language Bonnie will:
    8.1 say her first real words with meaning- mama, dada, bye,bye + R
    8.2 look at the ball when asked, "wher~~e is the ba~~ll?" + where's "momma"
    8.3 initiates speech gesture games like pat-a-cake, peek-a-boo +

SELECTED INTERVENTIONS

The following, selected from a voluminous resource file, were written by six different Core Mothers between March, 1977 and November, 1979. In the interest of legibility, several have been typed although in fact interventions are almost always handwritten. They were chosen to illustrate individual Core Mother's writing style as well as general changes in attitudes about writing interventions during NSSI's early years.

Interventions are reviewed by Case Managers prior to home visits and are frequently planned during case management meetings. The Occupational Therapist is sometimes consulted informally during these discussions or at IPP meetings. She might suggest specific activities or materials, refer the Core Mother to reference materials, or locate past interventions from the resource file. A copy is left with the parent.

Unless NSSI develops a system for a parent, such as a note-book, they rarely save interventions for more than a few weeks and they often do not fill in the response blanks. Core Mothers feel that except in cases of handicapping conditions requiring specific "therapy", interventions primarily serve to organize their teaching strategy at the home visit. Most parents, on the other hand seem to rely on their memory rather than written instructions.

SSI Intervention Sheet For week of 3/13/78

Child's name Julie Core Mother Barbara

Goal:

Increase Receptive Language

Objective:

Julie will have regular time in day to look at books. Julie will have her own book.

Materials:

Book

ACTIVITY:

1. Have Julie look at the book with Mom.
2. Pick out particular pictures such as dog, cat or shoe.
3. Let her look at as many pictures as she wants but keep going back to the "dog" and say "look at the dog".
4. Let Julie turn the pages if she wants to.
5. Repeat #3 to see if Julie will point to the dog when you say "where is the dog Julie?
6. Praise any attempt at pointing or turning the pages.

Parent's Comments about Activity:

Did you make any additions?

Did you have any problems?

Number of times activity completed:

M	T	W	TH	F	SA	SU

This intervention contains several skill objectives: pointing to a named picture, turning pages, and visual attention. For this disorganized parent, however, establishment of a "quiet time" for herself and her child was emphasized as the primary objective. This style has been developed by other BEH projects and was used extensively in the first year. Core Mothers found that writing a step-by-step activity helped them to organize the components of an intervention but felt that in the client home it was artifical and wordy, especially for parents who were poor readers. Educated parents were insulted by the simplicity of the instructions.

Referring Diagnosis: Multiple Congenital Anomalies

MSSI Intervention Sheet

For Week of 11/7/77

Child's name Jackie

Core Mother Barbara

Goal: Improved grasp (Fine Motor)

Objective:
Jackie will use radial digital grasp

Materials:

ACTIVITY:

1. Let Jackie get the wallet.
2. She may have a little trouble opening the clasp but she can do it.
3. Let her pull out the papers and put them back in if she wants to.
4. When she looks at the pictures say "See the baby" "See the puppy"

Parent's Comments about Activity:

Did you make any additions?

Did you have any problems?

Number of times activity completed:

M	T	W	TH	F	SA	SU

5. If she opens the snap on the change purse don't worry, all that is in there she can play w

INTERVENTIONS DEVELOPED DURING RESPITE

CM's often try out new activities during respite. Then they can feel confident that the parent and child will succeed at the intervention.

Referring Diagnosis: Orthopedic Handicap [illegible] [illegible]

's name Erick

Core Mother Pat Lane

-creasing expressive speech

# of times activity completed

M	T	W	Th	F	S	S

tive:

Erick will learn 1-3-5 new words

Comments about activity:

Did you make additions ?

Have any problems ?

ials:

2 toy phones.

ITY:

. Give Erick a phone + you take one.

Dial 1 or 2 numbers + say "Erick", he will probably be holding his because he loves his phone.

3. Say "Hi, Erick" 2 or 3 times waiting between words to see if he say Hi or Mommy.

4 Say "I love you", "Want to eat, Erick" or what ever might be appropriate to what time of day it is. Keep the words simple + short, he will try to talk back + will after a week be bringing the phone to you to talk.

Interventions are often designed for a specific child following a home visit. Here the CM observed child's play with favorite toy and built an intervention around it. Our purpose is to teach parents to expand on their children's play and to downplay the use of special "educatonal" materials.

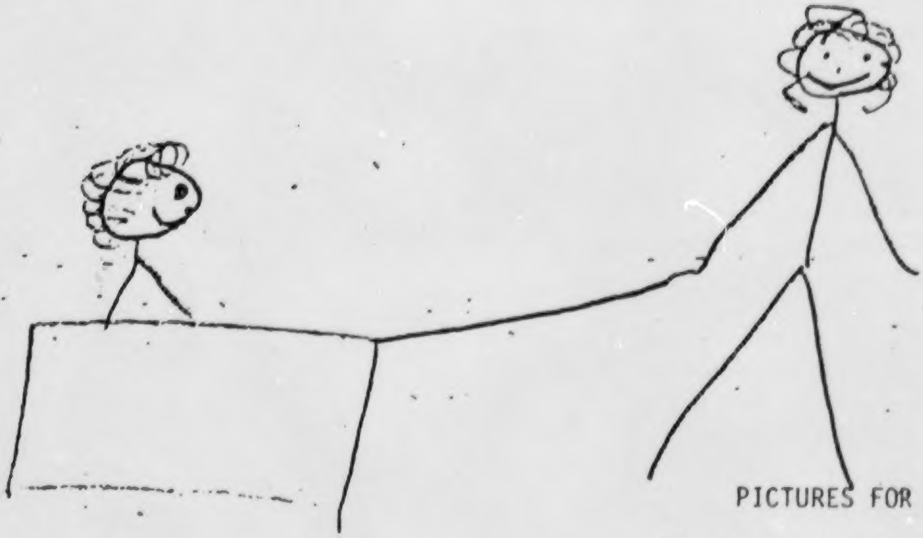
Referring Diagnosis: Muscle weakness, unknown etiology

Elm[illegible] Core Mother Pat

# of times activity completed

M T W Th F S S

Comments about activity: Did you make additions ? Have any problems ?



PICTURES FOR NON-READERS

Pictures and single block printed words were used for this parent with minimal reading skills. Whereas this mother lost written interventions she hung these on her kitchen wall to remind her to play with her son.

Referring Diagnosis:
Failure to thrive, delayed development

MSSI Intervention Sheet

For week of 12/26/78

Child's name Eric

Core Mother Cathy S.

Goal:

Parent concerns

Objective:

Discuss with parents any questions they may have.

Materials:

ACTIVITY:

1. I arranged to come at a time when Eric's dad would be home.
2. I talked with both mom and dad about Eric's progress.
3. I tried to encourage them to verbalize any questions they may have.
4. Since my visit was so close to Christmas the parents were not into future plans or needs at this time; however, I hope to approach the subject in subsequent visits.

Parent's Comments about Activity:

Did you make any additions?

Did you have any problems?

Number of times activity completed:

M	T	W	TH	F	SA	SU

INTERVENTION FOR PARENT OBJECTIVES

CM's plan their visits in accord with parent objectives set in the IPP. Some CM's record their plans as interventions for themselves and attach these to interventions aimed at parents and organizing, thinking before a home visit.

This intervention, however, is not given to the parent.

Referring Diagnosis: Down Syndrome, Leukemia

Weekly Intervention Sheet [illegible]

- 111 -

Child's Name Jason

Core Mother Martha

Date 4/17/78

Goal:

Improve Gross Motor Development.

# of times activity completed

M	T	W	Th	F	S	S

Objective: Mother will hold Jason as the figure shown by enabling him to explore his surroundings.

Materials:

Comments about activity:

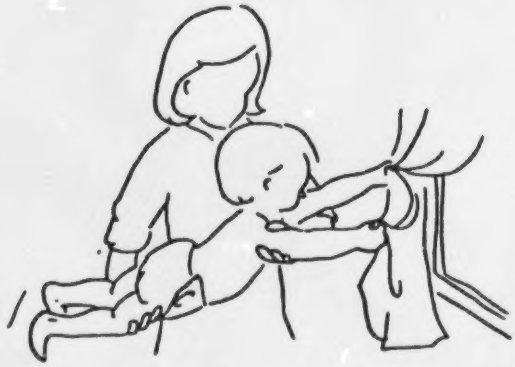
Did you make additions?________________

Did you have any problems?________________

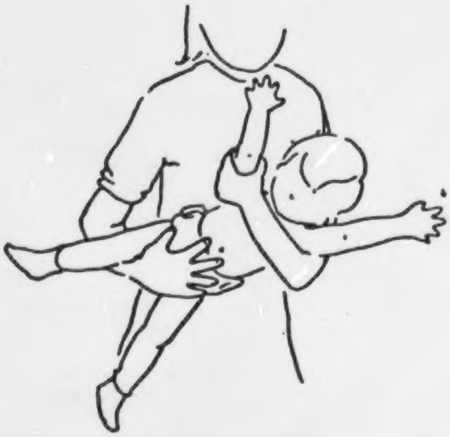
Activity:

This position facilitates the lifting of the head extension of the back and the reaching out of both arms.

↓



(b)



(a)

Pictures are used to illustate positioning for physicall handicapped infants. Handlinc the CP Child At Home.* has been our most used resource.

This particular intervention was used after a weekly physical therapy visit to illustrate the therapists instructions about handling.

*by Nancie R. Finnie, E.P. Dutton N.Y. 1975

Referring Diagnosis:

Athetord Cerebral Palsy

MSSI Intervention Sheet

For week of 11/20/79

Child's name Karla

Core Mother Donna

Goal: Gross Motor

Parent's Comments about Activity:

(English) Objective:
While standing at furniture Karla will turn and pick up a toy placed beside her on the floor.

(Spanish)
Quando está de pie cerca de las muebles, Karla traerá uma juguete que está al suelo.

(English) Materials:
A ballon or favorite toy.

(Spanish)
Un jugueta favorito o un glovo.

ACTIVITY:

(English)

1. Have Karla stand holding onto a chair (adult-size)
2. Sit on the floor behind her and put a toy on the floor on either side.
3. Encourage her to reach down and pick it up.

(Spanish)

1. Karla está de pie al suelo asiendo se a una silla grande.
2. Siéntese al suelo detrás de ella y ponga un jugute al suelo a un lado o el outro de ella.
3. Digale, "Mua el juquete! Vengatrael".

M	T	W	TH	F	SA	SU

SPANISH/ENGLISH

Interventions are written in Spanish for Spanish speaking clients. The English verson is filed as a resource to other CM's.

d's name Shannon 5-15-78

Core Mother Barbara

: Increase Adaptive Reasoning & Language

tive: Shannon will match similar objects.

ials:

ITY:

# of times activity completed

M	T	W	Th	F	S	S

Comments about activity:

Did you make additions ?

Have any problems ?

cognitive 18

AGE 1-2

TITLE: Matches like objects

WHAT TO DO:

1. Begin with four objects the child is familiar with (2 balls, 2 dolls, etc.) Hold one ball and ask child to "Find the other ball." Repeat for dolls. Gradually increase the number and kinds of objects to match.
2. Repeat above activity using pictures instead of objects.
3. For variety, use 2 paper bags with identical objects. You pull and object from your bag and ask the child to find the same object in his bag.
4. Let child try to sort silverware or white tee-shirts from dark socks or apples from oranges in a bin. Give him a model by putting out one place setting, a tee-shirt and a sock, etc.

Portage Guide

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USING OTHER FORMATS

Interventions from a variety of curricula are copied without being revised into the NSSI style. We have found that occasionally changing format keeps both CM's and clients interested in interventions.

Referring Diagnosis: At risk subsequent to newborn meningitis [illegible] Ov [illegible]

's name Randy -113- Core Mother Frances

# of times activity completed

M	T	W	Th	F	S	S
	6	–	9	months		

Gross Motor-Lang

ctive:

Strenthening back

ials:

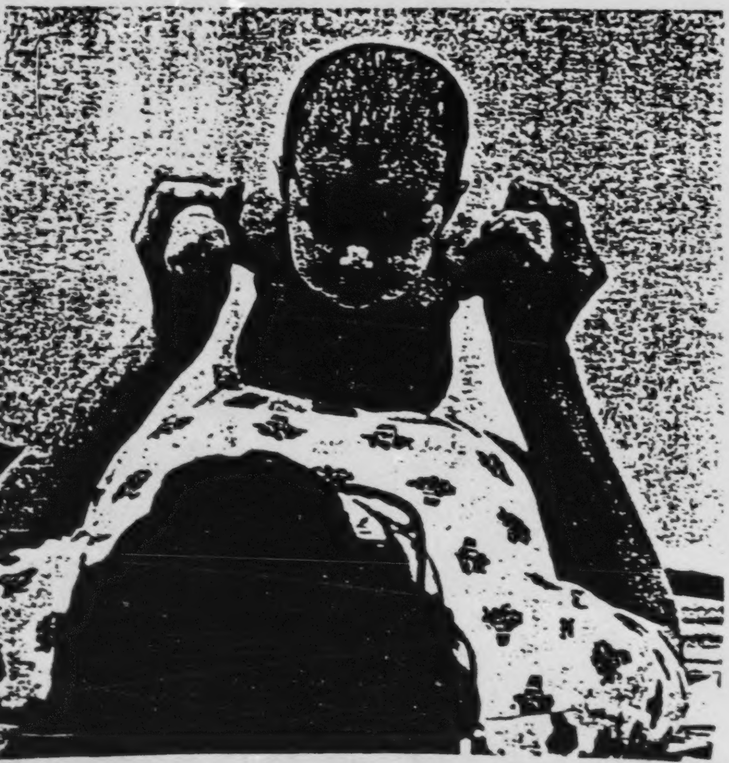
ITY:

Photographs have been helpful when we suggest activities that may seem unusual to a parent.

Core Mothers have commented that notes added by the professional staff add credibility to the interventions. Their purpose is to help both CM's and parents generalize beyond a specific activity sequence.

Referring Diagnosis: Prematurity, Motor Delay

1. Lay on your back with Randy on tummy
2. Talk to him about your nose, mouth, etc.
3. Encourge him to reach



* This activity provides lots of diffirent stimulation for Randy: It gives him the feeling of being straight on his tummy, he can feel your touch and warmth, and it gives him a chance to be face to face with you.

MSSI Intervention Sheet

For week of 10/9/78

Child's name John

Core Mother ____________

Goal: Improved Language

Objective: Now will continue to help John build on his receptive language.

Materials:

ACTIVITY:

1. Your child will learn words more easily if, as he can hear the word, he can see it, feel it, and perhaps smell, eat or drink it.
2. In the normal course of your day's activities name things in the house or yard, slowly one at at time and have him touch them.
3. Start with parts of the body. "Where is John's knee?" putting his hand on his knee if necessary.
"This is a banana" Put it under his nose to smell. Have him take a bite.
"This is the light" Let him turn it off and on as you say "light".

Parent's Comments about Activity:

____

____

____

Did you make any additions?

____

____

Did you have any problems?

____

Number of times activity completed:

M	T	W	TH	F	SA	SU

CM's developed this style of intervention writing as they became more experienced. It begins with a theoretical statement and proceeds to describe general and then specific activities. Monitoring is accomplished by asking a parent to keep a "running" list of words understood by her child.

Referring Diagnosis: Language Delay

Form # ID 3/23/79

NSSI

HOME VISIT CHECK LIST

Child's name ______________________ Core Mother ______________________

# of Visit ______________________ Report for week of (Monday's date) __________

Dates and Times of Home visits ______________________________________

Was parent home? __________ ______________

To keep better track of our different contacts with families, please separate "regular" home visits from respite or doctor's appointments, etc. "# of visit completed" means regular home visits.

This form should be completed weekly by Monday of the week following the home visit. Even if you make more than one visit/week, you should fill out only one check list. This form should be filed in the Case Manager's box.

A. Greeting

1. Did you suggest a place to work?(set conditions for conversation) Yes___No___
2. Did you have tea or coffee? Yes___No___
3. Where did you meet? ______________________________________
4. Who was present ______________________________________

____

B. Discussion of Previous Week's Interventions:

1. Did the parent complete the interventions? Yes___No___
2. Were there any problems? Yes___No_____

If yes, explain ______________________________________

____

____

3. Did the parent modify the planned intervention? Yes___No____

If yes, explain: ______________________________________

____

C. New Interventions

1. Did you explain the rationale for the new intervention? Yes____No____
2. Did you introduce and explain use of new materials or equipment? Yes___No___
3. How did you present the new intervention? Check all that apply.
   - a. presented paper instructions______
   - b. discussed instructions________
   - c. modeled interventions with parent in the role of learner____
   - d. Core Mother presented intervention by modeling with child_______
   - e. Parent modeled intervention with Core Mother______
   - f. Parent modeled intervention with child______
4. How did parent react to instructions of new interventions?
   - a. Looked at you while you were talking and/or asked questions?______
   - b. Did other things while you were explaining interventions (examples: housework, watched TV)______
   - c. Walked out of the room while you were talking________
   - d. Laughed at or scoffed at instructions________
   - e. refused to do intervention

5. Was the client able to repeat the interventions?
    a. she could repeat interventions that Core Mother had explained.__________
    b. she could do part of the interventions but needed Core Mother's help_______
    c. she could not repeat interventions________
6. What kinds of interuptions were there on the visit?
    a. mother had to care for another child______
    b. the phone rang______
    c. visitors came________
    d. the baby had to be fed_____
    e. the baby had to be put to sleep_____
    f. other_______________
7. How did the child react to the interventions?
    a. he/she was interested and attentive_____
    b. he/she was hard to motivate_______
    c. the intervention was too difficult______
    d. the intervention was too easy, he/she did it very quickly and was bored_____

    e. other____

8. Did you and parent review the child's IPP? Yes____No____
9. Did you confirm the next visit? Yes____No____ For when?________________
10. Did you make appropriate program announcements? Yes___No____ Which ones?

____

11. Subjective rating of home visit. How do you feel the home visit went? Since everyone has their own criteria, please five one example of what happened that made you arrive at that rating.

Highly successful		Moderately successful		unsuccessful
5	4	3	2	1

____

____

D. Respite Care

Date	Hours	# of children

1. What did you do?________________________________

____

2. How did the children react?________________________

E. Other contacts with parent during the week: (Green form for Dr. visit)

1. phone conversations

date	who called	who was called	message

2. Did you provide other transportation (to parent groups, DPW,etc.) Please describe.

3. Contacts with other agencies about this client:

4. Is there any other information that you think is important?

NSSI WEEKLY CONTACT REPORT

CONTACT ________

DATE ________

CORE MOTHER ________ CLIENT MOTHER ________

____

THIS REPORT DESCRIBES a

☐ HOME VISIT

☐ RESPITE

☐ TRANSPORTATION*

OTHER ________

HOW LONG DID THE CONTACT LAST! ________

WHO WAS PRESENT? ________

WHERE DID THIS CONTACT HAPPEN? ________

---

1. THIS WEEKS PLAN:

2. ANY CARRY OVER OR COMMENT ABOUT LAST WEEK!

3. IF YOU PRESENTED INTERVENTIONS, COMMENT ON:
   a) MOTHER'S REACTION:
   b) CHILD'S REACTION:

* transportation to a medical facility should be recorded on medical form

4. WHAT OTHER INTERACTION DID YOU OR THE MOTHER HAVE WITH THE CHILD, BEYOND THE INTERVENTIONS, WHICH WAS IMPORTANT.

5. SPECIAL CONCERNS THAT WERE ADDRESSED:

. DESCRIBE THE PIECE OF WORK WHICH WAS MOST IMPORTANT.

. IF POSSIBLE, WHAT WOULD YOU CHANGE ABOUT THIS VISIT?

. PHONE CONTACTS WITH PARENTS DURING THE WEEK.

DATE	WHO CALLED	MESSAGE.

SSI WEEKLY CONTACT REPORT

CONTACT ____________

DATE ____________

CORE MOTHER ____________ CLIENT MOTHER ____________

____

THIS REPORT DESCRIBES A

☐ HOME VISIT

☐ RESPITE

☐ TRANSPORTATION

OTHER ____________

HOW LONG DID THE CONTACT LAST? ____________

WHO WAS PRESENT? ____________

WHERE DID THIS CONTACT HAPPEN? ____________

THIS WEEKS PLAN ____________

WHAT INTERACTION DID YOU HAVE WITH THE MOTHER OR CHILD

WHAT INTERACTION DID THE MOTHER HAVE WITH THE CHILD

DESCRIBE THE PIECE OF WORK WHICH WAS MOST IMPORTANT

(EXAMPLE " SPECIAL CONCERNS THAT WERE ADDRESSED

5 PHONE CONTACTS WITH PARENTS DURING THE WEEK

DATE	WHO CALLED	MESSAGE

A Core Mother's Report on Crisis Intervention with One Family

Friday June 29: Sandy called, Chuck beat her and she wants out. I gave her Transition House and Respond numbers; told her to call me when she needs me.

Sunday July 1: 11:30 p.m. Sandy called. Chuck had gone out and she wanted to get out. Again I had her call Transition House but when she didn't call me back I thought she had gone. I was away till late Tuesday July 3.

Wednesday July 4: Sandy called from her mother's. She said Chuck came home at 3 a.m. Monday morning and then left again. He returned at 9 a.m. and said he had been arrested for drunk driving and had paid $100 and had been released. She said she saw the receipt from the clerk. He fell into bed still half drunk and very tired from being up all night. She tells me she then packed up the kids and walked to her mother's with nothing but the clothes they were wearing. She says she now wants to get Chuck out of the house so that she can move back in with the kids and still be assured of her safety. I told her to go to court and get the 209A restraining order and then demand that she get the police to remove him. She will call me 7/5 to let me know what she has done.

Monday July 9: I called Sandy and she said she had gone to Somerville Court and Judge Tampone had made very light of the 209A and put a return date of 7/23 on it. I suggested she call Lorraine (MSW from Massachusetts Department of Public Welfare.) At 3 p.m. I saw Lorraine Monreale in Union Square. She had brought Sandy to the Police Station to report that Chuck stole her checks and the rental car which was rented in Sandy's name.

Tuesday July 10: I picked Sandy up at 8:45 to take her to Cambridge and Somerville Legal Services to get help on a restraining order (209A). After depositing her in the proper place, I told them I would be in probate section of old court building. Lorraine Munroe (the legal aid) and Sandy met me after going to Judge McGovern. The return date is 9:30 Friday July 13. Sandy asked if while we were out could she stop at Cambridge Hospital and get a pre-natal check. (We went and after four doctors and two nurses saw her, we were told that the baby is breech. She has to have a B-scan 7/16 and return on 7/17. We then went to Somerville Police to leave their copy of 209A and write out report of stolen check and food stamps. From there we went to Gil Riberio, the notary public, to have him serve the warrant for 209A.) It was noticed by his secretary that the address, 85 Central Street was not on the restraining order. I hope that doesn't screw anything up. From there we went to Welfare to get A&P for food stamps and her social worker, Arian Reeves, said nothing could be done without a letter from Police of stolen report so I pulled rank and went to Ann Lenihan, the director. She called Sgt. Rickey of Somerville Police and then ordered Arien Reeves to give up the A&P and Identification papers for food stamps. I took Sandy home at 2:50 I wasn't able to get Lorraine Monreale to give her an update.

Friday July 13: I took Sandy back to court and she got the fully authorized 209A.

Sunday July 15: 10:30 p.m. Betty C. called. Sandy had her baby, a boy, Saturday morning at 5:55. He weighed 7 lb. 9 oz. and is named Michael Christopher Connelly. Betty's concern was that Chuck had been to the hospital on Sunday and caused a rumpus and security had refused to remove him. He also sent home all her company.

Monday July 16: I arranged with Betty to pick up Patty and Chuckie at 7:45

Monday morning and keep them as Patsy had been drinking again and therfore couldn't be counted on as a sitter. I arrived and took Chuckie and Patty to my house and drove Betty to work. I went directly to Cambridge Hospital. The desk didn't want me to be admitted and I said I was from NSSI and they could call Sheri Atkinson-Mallory if they had questions. I then went to see Sandy and she beamed and said I was the first person she had seen since Saturday that she was happy to see.. She asked if I knew about Chuck being in the hospital and bothering her. She cursed Security for not removing Chuck and I said I would go and straighten it out. I spoke to the nurses and they didn't know what to do. I went in to see Sandy and told her I would go to Security Office and Sheri Mallory. I had no luck at either place and returned to the floor. Just after I arrived in came Chuck The nurses told him to wait at the desk, he couldn't come in yet. He said "I am her husband and I can stay". He thereby said he had a .45 (gun) and would get me. He left and security sent him out of the building and told him not to return. Sandy will be discharged today after the baby is circumcised, and I will take her to her mother's but I will keep Patty and Chuckie at my house till she is feeling better. Dr. Osler saw the baby and said he wants to see the baby tomorrow morning. I left at 10:30 and had Security escort me to my car and the hospital will call when Sandy can leave.

Tuesday July 17: I went to pick up Sandy and Michael and took them to Dr. Osler's office fo a check up then I returned her to her mother's. At 4 o'clock in the afternoon I lay down with little Chuckie and he felt warm. When I took his temperature it was 103.8 and I called Somerville Pediatrics and took him right up. Dr. Osler said he had two ear infections and put him on Amoxicillin 1 tsp. 3 + 1p. Sandy called in the evening and said she wanted the kids home. I took them home at 1:30 p.m. Wednesday.

Wednesday July 17: Betty called me. She returned from work and found Sandy and the kids gone, Patsy and Lynn weren't around and she was nervous. I went for a ride by Sandy's house and there was a window open a little. I didn't stop but I then went by Chuck's mother's house and he was sitting in the yard. He yelled something threatening at the car but I never stopped. I then went home and called Betty. She said she had called Sandy's house and Sandy told her she had gone back to Chuck and for everyone to stay out of her life. Both Betty and I were concerned because she had taken little Chuckie out with a fever and she had not taken his medicine.

TEST SCORES* OF NSSI CHILDREN
ON BAYLEY SCALES OF INFANT DEVELOPMENT

SUB-GROUP	NUMBER OF EVALUATION						
	1	2	3	4	5	6	7
A Abnormal Muscle Tone							
1.	67/91 6 mos.**	90/98 11 mos.					
2.	91/107 18 mos.	94/90 24 mos.	104/94 33 mos.				
3.	62/61 2 mos.	50/50 6 mos.	52/50 9 mos.				
4.	91/106 5 mos.	130/119 8 mos.	100/125 12 mos.				
5.	104/97 5 mos.	74/NA 11 mos.	101/95 15 mos.				
6.	79/57 7 mos.	119/NA 12 mos.	126/80 15 mos.	109/NA 21 mos.	110/NA 26 mos.		
B Congenital Anomalies							
1.	86/117 7 mos.	88/NA 11 mos.	92/NA 15 mos	66/NA 19 mos.			
2.	92/64 8 mos.	100/60 12 mos.	50/NA	83/50	100/50		
3.	84/NA 19 mos.	79/102 26 mos.	86/NA 30 mos.				
4.	113/114 4 mos.	NA	NA	98/88 18 mos.	97/NA 21 mos.	94/79 25 mos.	
5.	80/97 5 mos.	101/104 8 mos.	109/98 11 mos.				
F Failure to Thrive							
1.	109/118 15 mos.	110/NA 20 mos.	145/NA 24 mos.	124/143 29 mos.			

TEST SCORES* OF NSSI CHILDREN
ON BAYLEY SCALES OF INFANT DEVELOPMENT

SUB-GROUP	NUMBER OF EVALUATION						
F	1	2	3	4	5	6	7
Failure to Thrive (cont)							
2.	70/83 5 mos.	64/75 9 mos.	70/82 13 mos.				
3.	50/NA 14 mos.	50/NA 22 mos.	59/NA 27 mos.				
4.	98/102 9 mos.	65/81 14 mos.	74/NA 17 mos.	53/70 21 mos.	72/70 25 mos.	85/78 29 mos.	97/104 33 mos.

* Scores reported are those for children in three sub-groups who had at least two evaluations. Includes terminated and current clients.

** Mental score/motor score
Age at evaluation

UTILIZATION OF SERVICES IN NSSI BY CLIENT, 12/1/76 to 3/31/79

LOT - length of time in program if client is current LOT is length of time between entry and 3/31/79.
HV - home visit
DR - doctor's visit
R - respite
NS - no show

Clients are organized by category and sub-groups.

Category I Established Risk (B,D,G,J,K,)

Sub-Group B: Congenital Anomalies

1. H.B. hemangioma, deaf
   Age at Entry: 5m
   LOT: 4m terminated
   26 HV - R 6 NS - DR
2. J.C. metatarsus abductus
   Age at Entry: 4m
   LOT: 9m terminated
   54 HV 12 R 2 NS 9 DR
3. S.F. congenital heart problem
   Age at Entry: 7m 28d
   LOT: 23m current
   76 HV 16 R 9 NS 20 DR
4. S.L. cleft lip and palate
   Age at Entry: 1y 5m
   LOT: 17m terminated
   52 HV - R 1 NS 4 DR
5. J.M. multiple congenital anomalies
   Age at Entry: 11d
   LOT: 28m current
   65 HV 9 R 10 NS 13 DR
6. J.MCK. cleft lip and palate
   Age at Entry: 1y 10m
   LOT: 25m current
   1 HV - R - NS - DR
7. T.S. cleft lip and palate
   Age at Entry: 4m 22d
   LOT: 1m current
   3 HV - R - NS - DR

Sub-Group D: Visually Impaired

1. T.G. undiagnosed
   Age at Entry: 7m
   LOT: 1m terminated
   1 HV - R 4 NS - DR

Sub-Group G: Cerebral Palsy

1. J.G.
   Age at Entry: 3m
   LOT: 18 m terminated
   23HV 12 R 1 NS 6 DR
2. R.L.
   Age at Entry: 1 y
   LOT: 12 m current
   23 HV - R 2 NS 1 DR
3. J.M.
   Age at Entry: 11 m
   LOT: 15 m current
   40 HV - R 4 NS 22 DR
4. J.V.
   Age at Entry: 2 y 2 m
   LOT: 9 m terminated
   18 HV 13 R - NS 12 DR

Sub-Group J: Genetic Syndrome

1. E.L. Down's syndrome
   Age at Entry: 2 1/2 m
   LOT: 9 m current
   26 HV - R - NS 1 DR
2. J.V. Hurlers syndrome
   Age at Entry: 2 y
   LOT: 1 m terminated
   5 HV - R - NS 1 DR

Sub-Group K: Brain Dysfunction

1. T.A. blind microcephaly
   Age at Entry: 1 y 9 m
   LOT: 18 m terminated
   53 HV 1 R - NS 8 DR
2. F.B. acortical brain damage
   Age at Entry: 11 m
   LOT: 15 m current
   40 HV 14 R - NS 8 DR
3. E.D. congenital brain dysfunction
   Age at Entry: 14 m
   LOT: 15 m current
   47 HV 3 R 11 NS - DR
4. N.Z. brain damage due to interuterine stroke
   Age at Entry: 8 m
   LOT: 9 m terminated
   13 HV - R - NS - DR

Category II Medical Risk (A,C,E,F,H,L,N,)

Sub-Group A: Abnormal Muscle Tone

1. A.B. increased tone, lower extremities
   Age at Entry: 6 m
   LOT: 9 m current
   15HV - R - NS 11 DR

2. M.G. femoral abductus, increased tone
Age at Entry: 1 y 7 m
LOT: 16 m terminated
18 HV - R 3 NS - DR

3. A.H. scoliosis
Age at Entry: 2 m
LOT: 9 m current
28 HV - R 1 NS 6 DR

4. S.M. increased tone, alternating strabismus
Age at Entry: 2 m
LOT: 5 m current
16 HV 4 R - NS 9 DR

5. C.N. hypotonicity in shoulder girdle, bulging fontanel
Age at Entry: 4 m
LOT: 5 m current
20 HV - R 2 NS 3 DR

6. T.N. tight hips
Age at Entry: 6 m 12 d
LOT: 2 m current
63 HV 10 R - NS 8 DR

7. D.S. increased tone, upper and lower extremities
Age at Entry: 7 m
LOT: 18 m current
63 HV 10 R - NS 8 DR

8. T.W. hypotonicity
Age at Entry: 3 m
LOT: 1 m terminated
2 HV - R - NS - DR

Sub-Group C: Prematurity and Related Complications

1. E.L. occipital encephalocele
Age at Entry: 3 2/3 m
LOT: 1 m current
3 HV 2 R - NS - DR

2. E.L. hyaline membrane
Age at Entry: 3 2/3 m
LOT: 1 m current
3 HV 2 R - NS - DR

3. R.P. prematurity, asthma/chronic pulmonary condition
Age at Entry: 3 m
LOT: 19 m current
53 HV 4 R 8 NS 3 DR

4. S.P. retrolental fibroplasia, bronco-pulmonary displasia, hydrocephalus
Age at Entry: 4 m
LOT: 4 m current
9 HV - R - NS - DR

Sub-Group E: At Risk Secondary to Neonatal Complication

1. S.C. post viral/meningitis
Age at Entry: 4 m
LOT: 4 m current
60 HV 23 R 2 NS 5 DR

2. T.T. small for gestational age, high risk
   Age at Entry: 29 d
   LOT: 4 m current
   6 HV - R 3 NS - DR
3. J.W. apnea-on monitor (cardiac)
   Age at Entry: 4 m 18 d
   LOT: 2 m terminated
   3 HV - R 2 NS - DR

Sub-Group F: Failure to Thrive

1. R.B. failure to thrive, overactive
   Age at Entry: 15 m
   LOT: 15 m terminated
   44 HV 35 R 1 NS 1 DR
2. B.B. developmental delay
   Age at Entry: 1 m 4 d
   LOT: 10 m current
   17 HV - R 5 NS 7 DR
3. G.M. psychomotor retardation
   Age at Entry: 16 m
   LOT: 12 m current
   36 HV - R - NS 7 DR
4. E.M. developmental delay
   Age at Entry: 9 m 13 d
   LOT: 17 m current
   73 HV 3 R 14 NS 4 DR

Sub-Group H: Motor Delay Undetermined Origin

1. E.MC.
   Age at Entry: 9 m
   LOT: 17 m terminated
   50 HV 14 R - NS 4 DR

Sub-Group L: Congenital Virus

1. K.A. rubella, visually handicapped
   Age at Entry: 10 m
   LOT: 24 m terminated
   38 HV - R 14 NS - DR

Sub-Group N: Seizure Disorder

1. B.C. seizures
   Age at Entry: 6 m
   LOT: 6 m terminated
   6 HV - R 4 NS - DR
2. M.C. infantile seizures
   Age at Entry: 6 m
   LOT: 18 m terminated
   28 HV 7 R - NS 1 DR

3. T.F.
   Age at Entry: 2 y 3 m
   LOT: 6 m current
   9 HV 9 R 4 NS - DR
4. K.J.
   Age at Entry: 7 m 2 d
   LOT: 4 m current
   10 HV 6 R - NS 2 DR

Category III Enviromental Risk (I,M,O,P,Q)

Sub-Group I: Language Delay (Etiology may be unknown and presumed environmental, but may also present with suspicious medical history.)

1. J.G.
   Age at Entry: 2 y 2 m
   LOT: 6 m current
   18 HV - R 1 NS 1 DR
2. L.G. behavioral problems
   Age at Entry: 2 y 7 d
   LOT: 5 m current
   14 HV 4 R - NS 4 DR
3. S.G. speech delay, eye problem
   Age at Entry: 32 m
   LOT: 4 m terminated
   12 HV 3 R - NS 2 DR
4. P.H. delay speech motor, hyperactive
   Age at Entry: 1 y 7 m
   LOT: 16 m terminated
   68 HV 10 R 1 NS 2 DR
5. D.K. language delay, min. brain damage
   Age at Entry: 19 m 16 d
   LOT: 16 m current
   34 HV - R 4 NS 2 DR
6. M.M.
   Age at Entry: 2 y 3 m
   LOT: 9 m terminated
   30 HV 2 R - NS 12 DR
7. T.M.
   Age at Entry: 23 m
   LOT: 6 m terminated
   10 HV - R 1 NS 12 DR
8. B.O'B.
   Age at Entry: 30 m
   LOT: 7 m terminated
   4 HV - R - NS - DR
9. J.P. language delay, discipline/parenting
   Age at Entry: 1 y 10 m
   LOT: 3 m terminated
   12 HV - R 2 NS - DR

10. R.P.
    Age at Entry: 2y 3m
    LOT: 13m terminated
    23 HV 1 R 1 NS 1 DR

Sub-Group M: Abuse/Neglect (May be present with current 51A or historical, with foster placement.)

1. M.B. parenting/neglect
   Age at Entry: 5m
   LOT: 1m terminated
   10 HV - R 2 NS - DR
2. S.B. parenting/neglect
   Age at Entry: 19m
   LOT: 1m terminated
   10 HV - R 2 NS - DR
3. D.B.
   Age at Entry: 1y 11m
   LOT: 6m terminated
   14 HV 1 R 6 NS 5 DR
4. J.B.
   Age at Entry: 1y 11m
   LOT: 6m terminated
   14 HV 1 R 6 NS 5 DR
5. S.C. suspected abuse/neglect
   Age at Entry: 2y 3m
   LOT: 3m terminated
   11 HV - R 1 NS - DR
6. G.F. possible abuse/neglect, language delay
   Age at Entry : 2y 4m
   LOT: 7m terminated
   21 HV 3 R 6 NS 4 DR
7. J.G. parenting discipline abuse/neglect
   Age At Entry: 2y 3m
   LOT: 1m terminated
   4 HV - R 3 NS - DR
8. L.G. parenting support
   Age at Entry: 15m
   LOT: 5m terminated
   10 HV 1 R 2 NS 2 DR
9. S.P.
   Age at Entry: birth
   LOT: 11m terminated
   29 HV 8 R - NS 5 DR
10. R.P. parenting
    Age at Entry: 2y 1m
    LOT: 13m terminated
    53 HV 10 R - NS 7 DR
11. A.O.
    Age at Entry: 2y 4m
    LOT: 3m terminated
    6 HV - R - NS - DR

Sub-Group O: Parenting Support

1. M.F. discipline
Age at Entry: 4 m
LOT: 2 m terminated
6 HV - R 2 NS - DR
2. J.L.
Age at Entry: 16 m
LOT: 35 m current
1 HV - R - NS - DR
3. P.M. parenting, hyperactive
Age at Entry: 14 m
LOT: 2 m terminated
9 HV - R - NS - DR
4. M.MC. prematurity/at risk/abuse/neglect
Age at Entry: 25 d
LOT: 1.5 m current
1 HV - R 1 NS 1 SR
5. T.O'B.
Age at Entry: 2 y 7 m
LOT 1.5 m current
1 HV 2 R 1 NS 1 DR
6. S.R. allergy work up
Age at Entry: 10 m
LOT: 3 m terminated
8 HV 2 R 1 NS - DR

Sub-Group P: Focus on Parent Toddler Negativism

1. S.A. normal toddler/parenting difficulties
Age at Entry: 21 m 12 d
LOT: 5 m current
1 HV - R - NS - DR
2. D.D. parenting activity level
Age at Entry: 11 m
LOT: 5 m terminated
9 HV - R 1 NS - DR
3. J.L. parenting discipline/ allergy
Age at Entry: 2 y 9 m
LOT: 1 m terminated
6 HV - R - NS - DR
4. J. MC. discipline/safety issues
Age at Entry: 15 m 9 d
LOT: 6 m terminated
8 HV - R 5 NS - DR

Sub-Group Q: Medical Coodination and Translation for Non-English Speaking Portugese Families

1. P.B.
Age at Entry: 3 m 1 d
LOT: 2 m current
5 HV - R - NS 2 DR

2. M.M.
Age at Entry: 3m
LOT: 5m current
5 HV - R - NS 2DR

NSSI STAFF TRAINING ACTIVITIES, 1976-1979
YEAR ONE

TRAINING ACTIVITY	TEACHING FORMAT	CONTENT	SEASON & YEAR	LENGTH	WHO TAUGHT	WHO ATTENDED	COMMENTS
COUNSELING FOR NON-COUNSELORS 1	Presentation & Discussion		Fall 1976	8 2 hr. sessions	Community Training Resource (CTR)	* All Core Mothers	Core Mothers felt it was too long, also felt valuable in helping them to know themselves better. Bunker Hill Community College (BHCC) Credit
Conference of The Seminar in the Development of Infants & Parents	Lecture		Fall 1976	2 days	variety of doctors & child psychology research	Director/Nurse Practitioner	Information on mother-infant bonding especially useful
INFANT & TODDLER GROWTH AND DEVELOPMENT	Presentation and discussion	Normal growth and development from perinatal period to 36 mts.	Fall 1976	6 half day and 10 2-hour sessions	NSSI director Nurse Practioner	*All Core Mothers	Designed by administrative staff as a basic framework for working with children. BHCC Credit
Developing Short Term Goals for Children	Presentation & Discussion		Winter 1977	2 days	Connie Smiley, TADS Consultant	* All Core Mothers	Core Mothers felt comfortable talking with her about what they did not understand and from this inservice began writing program plans for children.
An Evaluation Plan for NSSI	discussion		Winter 1977	2 days	Neil Schortinghuis, TADS consultant	* Director/NP Occupational Therapist	Provided better understanding of amount of evaluation needed and emphasized need for more structure and clearer goals in all areas

1. Shaded inservice signifies that NSSI first defined a particular training need and then sought out a source of that training as opposed to other inservices which it participated in for other reasons (eg.) because it was relevent and available or to make contacts etc.

* NSSI Staff alone participated in this particular inservice

NSSI STAFF TRAINING ACTIVITIES, 1976-1979
YEAR ONE

TRAINING ACTIVITY	TEACHING FORMAT	CONTENT	SEASON & YEAR	LENGTH	WHO TAUGHT	WHO ATTENDED	COMMENTS
PRACTICUM AT MEDFORD PEDIATRICS ASSOCIATES	Observation of patient visits/discussion with NP	Medical background information on children whose visits were observed	Winter 1977	8 2hour session	Pediatric Nurse Practitioner in private group practice	* NP	NSSI saw few benefits from this inservice. It did not produce the hoped for referrals from Medford nor did NP get much relavent medical information on special needs children. She was most impressed with the severely limited role played by NP in this private practice.
ADMINISTERING THE BAYLEY SCALES OF INFANT DEVELOPMENT	Classroom observation of Bayley assessment	Developmental background on children assessed, description of Bayley item task and scoring	Winter 1977	2 2 hour sessions	Physical Therapist Consultant	* Director, NP	Of limited value because it was not done in a home setting with family members present and only profoundly involved children assessed. Also only individual items were demonstrated rather than complete Bayley's.
TADS Conference (Lakeland, Florida)	lecture/ workshop	Two separate tracts in conference: one offering a variety of information from nutrition counseling to oral-motor dysfunctions, the other programming for CP children.	Winter 1977	3 days	TADS Consultants	Director/ NP	Informal contacts with other participants especially important.
Abuse and Neglect Forum (Sponsor: Mass. Office for Children)	lecture/ workshop	Information on intervention, remediatian and legalities of abuse and neglect	Spring 1977	3 days		2 Core Mothers	One of the Core Mothers who attended requested going to this forum after seeing information on it in the office. This was an early example of Core Mothers self-selection of inservices.
The Importance of the First Three Years of Life	lecture	Normal growth and development in the first three years	Spring 1977	1 day	Dr. Burton White, visiting North Shore College	3 Core Mothers	Participants agreed they were exposed to disappointingly little not already covered in NSSI's internal Infant and Toddler Development training.

NSSI STAFF TRAINING ACTIVITIES 1976-1979
YEAR ONE

TRAINING ACTIVITY	TEACHING FORMAT	CONTENT	SEASON & YEAR	LENGTH	WHO TAUGHT	WHO ATTENDED	COMMENTS
Fifth Annual High Scope Conference (Ann Arbor, Michigan)	lecture/ workshop	Training, supervision, and evaluation of paraprofessional homevisitors	Spring 1977	2 days		Director	A few training video tapes developed at High Scope and discovered here were later shown to Core Mothers during internal training sessions.
Introduction to Down's Syndrome (Children's Hosp. Medical Center)	lecture		Spring 1977	2 days	Developmental Evaluation Clinic & Social Service Staff	Director/OT	
The High Risk Neonate	lecture	Definition of the high risk neonate and the issues that surround it, including early interventions in the Neonatal ICU	Spring 1977	1 day	Neonatologists & Peditricians	Director/ OT	
Oral-Motor Dysfunction (Sponsor Physical Therapy Dept. of University of North Carolina, Chapel Hill)	lecture/ workshop		Spring 1977	3 days	University of North Carolina faculty	OT	She gained skills in evaluating feeding and learned move about a developmental approach to assessing feeding problems.
DEATH AND DYING	discussion presentation		Spring 1977	2 2 hr. sessions		* All Staff	This inservice arranged to give Core Mothers insight into working with families of terminally ill children and simply dealing with the loss of their hoped-for normal child. One Core Mother better understood the denial of a mother of a severely-involved child in her case load. And she became convinced of the need to prepare his siblings for his probable death.

NSSI STAFF TRAINING ACTIVITIES, 1976-1979
YEAR ONE

TRAINING ACTIVITY	TEACHING FORMAT	CONTENT	SEASON & YEAR	LENGTH	WHO TAUGHT	WHO ATTENDED	COMMENTS
Language Development Seminar (Meeting Street School, Providence, RI)	lecture/ workshop		Spring 1977	1 day	Meeting Street School Staff	Director, 2 Core Mothers	The value of the Conference to Core Mothers seemed to derive from the confirmation it provided that they were capable of understanding and evaluating academic presentations.
NORMAL MOTOR DEVELOPMENT IN THE FIRST THREE YEARS AND ABNORMAL DEVIATIONS	Presentation	Information on normal development, cerebral palsy, & Down's Syndrome	Spring/ Summer 1977	3 2-hour sessions	Physical Therapist, Pre-School Unit	* All Core Mothers	Designed to acquaint Core Mothers with abnormal development which they had already or were likely to encounter with client children.
FRIDAY AFTERNOON INSERVICE	Presentation/ Discussion	On-going inservices internal to NSSI dealing with a variety of issues from presentation about a disease entrty like rubella syndrome to instruction about writing interventions to training film viewing.	Spring/ Summer 1977	12 2 hour sessions	NSSI Administrative Staff	* All Core Mothers	Begun as an on-going way to build training into NSSI. In retrospect see that many of the presentations done by administrative staff was too abstract and not enough related to Core Mother's day to day work.
Working With Family Members	Presentation/ Discussion		Spring 1977	8 2 hour sessions	Community Training Resources (CTR)	2 Core Mothers	Core Mothers felt the course was too brief but were pleased to have been shown a new approach to family interventions that set specific goals for individual family members BHCC Credits
Advanced Seminar On Infant Development	Presentation/ Seminar		Spring 1977	10 sessions	Weelock College Faculty	Director (Audited)	Taken in order to hear presentations by clinicians chosen because of

NSSI STAFF TRAINING ACTIVITIES, 1976-1979
YEAR ONE

TRAINING ACTIVITY	TEACHING FORMAT	CONTENT	SEASON & YEAR	LENGTH	WHO TAUGHT	WHO ATTENDED	COMMENTS
							the relevence of their particular expertice to practioners in the field of early intervention to present the NSSI model.
Introduction to Neuro-Developmental Treatment of Young Children With Cerebral Palsy	lecture		Summer 1977	2 days	Meeting Street School Staff	OT	She found it of such value that she applied to attend a 10-week course on the subject.

NSSI STAFF TRAINING ACTIVITIES, 1976-1979
YEAR TWO

TRAING ACTIVITY	TEACHING FORMAT	CONTENT	SEASON & YEAR	LENGTH	WHO TAUGHT	WHO ATTENDED	COMMENTS
MEETING THE NEEDS OF TWO YEAR OLDS	Presentation / Discussion	Normal behavior and needs of the two year old.	Fall 1977	2 2 hour sessions	Preschool Unit Consultant, Dorathy Sang	* All Core Mothers	Designed to help Core Mothers with programming for client children 18 to 30 months. As a result of it Core Mothers became more outspoken and persistant in reminding parents "that's just typical two year old behavior."
HOME VISITING SKILLS		Description of the homevisit structure, initiating and setting-up a contract with a client, defining your role, setting goals and termination. Emphasis on listening skills	Fall 1977	8 sessions	Community Training Resources, Suzanne Pratt	* All Core Mothers	This course was unavailable during year one and NSSI was uncertain that the information would be helpful to Core Mothers with 9 months of homevisiting experience. This experience, in fact, made the course even more relevent, Core Mothers felt in retrospect, because they had concrete questions to present BHCC Credit.
An Introduction to Alcoholism	Presentation /Discussion	Discussion of attitudes about alcoholism among participants, a definition of the problem in client families and the first steps of referral, anecdotal presentations from AA and Alanon members.	Fall 1977	4 2 hour sessions plus 4 Alanon & AA meetings	Cambridge & Somerville Program for Alcohol Rehabilitation. (CASPAR)	Director and all Core Mothers	This inservice was offered to NSSI by a local agency. Because of the anticipated benefits of contact with this agency as well as its addressing a problem common to the NSSI population, the offer was accepted. Core Mothers found it helpful in working with certain client mothers with whom they suspected alcohol abuse. And they used the CASPAR staff as on-going consultants around problems of this nature. BHCC Credit

NSSI STAFF TRAINING ACTIVITIES, 1976-1979
YEAR TWO

TRAINING ACTIVITY	TEACHING FORMAT	CONTENT	SEASON & YEAR	LENGTH	WHO TAUGHT	WHO ATTENDED	COMMENTS
IMPROVING YOUR WRITING SKILLS	Presentation/ Discussion	Practice with filling out forms, keeping a journal about client work. Emphasis on applied job skills.	Fall 1977	8 2 hour sessions	Cece Landoli, CTR	* 3 Core Mothers	Three Core Mothers who felt they needed to improve thier writinc skills elected to take this course. Core Mothers reported more ease in organizing their record keeping and more self- confidence in their writing skills.
Treatment of Children With Developmental Disorders- Conference	lecture	Focus on intervention with severly notorically involved children.	Fall 1977	2 days	Professionals brought together by, NICEDD, National Institute for Continuing Education in Developmental Disabilities	Nurse Practioner	Practitioner was impressed with the developmental approach to disabilities. She felt however that it was most useful to physical therapists working with institutionalized children of all ages and was of only overview value to her.
Parenting- Considering it within a Developmental Framework	lecture/ seminar		Fall 1977		Wheelock College Faculty	Director/ OT	Most material presented was too general to be useful to NSSI staff but they did meet useful contacts involved in parent education.
Seminar in the Development of Infants and Parents 2nd Annual Conference	lecture	Current research findings concerning parent and child interaction	Fall 1977	1 day	Physicians & Researchers in Early Childhood Development	Director/ OT	A paper about positive effect of peer interactions on toddlers presented by Dr. Judith Robestein stimulated NSSI to plan the childcare portion of Mothers' group.
Family Interactions	lecture/ seminar		Winter 1978	1 semester	Weelock College Faculty	Director	

NSSI STAFF TRAINING ACTIVITIES, 1976-1979
YEAR TWO

TRAINING ACTIVITY	TEACHING FORMAT	CONTENT	SEASON & YEAR	LENGTH	WHO TAUGHT	WHO ATTENDED	COMMENTS
Meeting the Needs of Disabled Infants and Their Families	Presentation/ Discussion	General overview of skills and knowledge needed in meeting the needs of this population.	Winter 1978	5 Sessions	Project Optimus Staff (another 1st chance Project in Quincy, Mass.)	2 Core Mothers	These Core Mothers were particularly interested in the opportunity to compare services provided by Project Optimus with NSSI services and talk with other homevisitors.
Independent Consultation: "Death and Dying"	one to one discussion	Discription of work with family to get specific suggestions for crisis and long-term goals	Spring 1978	1 session	CTR Trainee of "Death and Dying"	1 Core Mother	This Core Mother needed more specific consultation around a family with whom she worked who was in crisis about the guarded prognosis of one of its children.
Perinatal Factors and Developmental Disabilities (Western Mass Medical Center)	lecture/ workshop		Spring 1978	1 day	University of Massachusetts Medical Center Faculty, & Visiting Lecturers	All Core Mothers	This was elected by all Core Mothers because of interest in the subject and a day out of the office to meet other people doing work similar to theirs.
Project Evaluation, TADS Small Group Meeting University Of Massachusetts Medical Center	Presentation/Workshop		Spring 1978	1 day	TADS	Director/OT	This inservice consultation clarified the program's emerging conviction that a complete discription of each project component was a necessary preliminary to any evaluative effort
Oral-Motor Dysfunction- Conference	lecture	Concentration on early, normal oral development and the importance of it as a basis for understanding abnormal. Suzanne Evans Morris presented her films of normal & ab-	Spring 1978	2 days	Oral Motor & Nutrition Professionals	OT/NP	Normal oral-motor films were especially impressive because of the depth in which they looked at this development in young infants.

NSSI STAFF TRAINING ACTIVITIES, 1976-1979
YEAR TWO

TRAINING ACTIVITY	TEACHING FORMAT	CONTENT	SEASON & YEAR	LENGTH	WHO TAUGHT	WHO ATTENDED	COMMENTS
		normal oral motor development					
MONTHLY ALL-STAFF INSERVICE	Presentation/ Discussion	Variety of topics including writing interventions ,or introduction to parent infant interaction scales	Spring 1978	12 weeks	Administrative Staff	* All Staff	This inservice formed part of the impetus for administrative offers to seek further inservice to improve their skills in teaching adults.
INTRODUCTION TO SKILLS AND CONCEPTS IN SELECTED ADULT EDUCATION TEACHING MODLES	Presentation/Discussion	Concentration on an adaptation of Malcolm Knowles (Boston University) technique of adult education included material on understanding and motivating students writing goals and objectives	Spring 1978	4 sessions	CTR	* Director/ OT/NP	Designed by the NSSI director and CTR instructor to improve administrative staffs skills in teaching Core Mothers as well as growth and development courses offered as well to community child care workers. It was most useful in goal and objective writing practice.
Recordkeeping-TADS Small Group Meeting	Presentation/Workshop		Spring 1978	2 days	TADS	Director	Developed a new homevisit form which was longer and which was later completely revised.
Winston Prouty Center, Brakebero, VT.	Discussion Observation	Observed classroom assessment met at length with Director Dr. Robert DeVoid	Spring 1978	1 day		Director, 3 experienced Core Mothers	Discussion with teacher, speech Therapist and director very useful. Although Vermont Staff had very different experience home visiting.
Giving and Receiving Feedback	Discussion	Detailed discussion of administrative work roles with appropriate reassignment of working relationships among staff	Spring/ Summer 1978	4 2 hour sessions	Pat Pappernow Educational Consultant through CTR	* Director/OT/NP	The most valuable outcome of this inservice was its design of the Case Manager role.

NSSI STAFF TRAINING ACTIVITIES, 1976-1979
YEAR THREE

TRAINING ACTIVITY	TEACHING FORMAT	CONTENT	SEASON & YEAR	LENGTH	WHO TAUGHT	WHO ATTENDED	COMMENTS
INTRODUCTION TO PROJECT HOPE	Presentation /Discussion	Variety of information to acquaint staff with Project HOPE goals and objectives, curriculum, and recordkeeping as well as the related issues of adolescence, adolescent parenting and neonates.	Fall 1978	1 week	NSSI Administrative Staff and outside professionals	* All Staff	This inservice was not only an introduction to Project HOPE, but for the two newly-hired Core Mothers' was an introduction to the program and their jobs as well. Feedback from all Core Mothers, especially those just-hired,was that there was too much information presented to thoroughly digest. And an on-going orientation to project HOPE was still necessary to clarify this extension of NSSI to all Core Mothers.
GROWTH AND DEVELOPMENT IN THE FIRST THREE YEARS	Presentation/Discussion	Normal growth and development beginning with prenatal issues and including bonding, motor, cognitive emotion development, safety needs, nutrition, appropriate toys.	Fall 1978	10 2 hour sessions	Administrative Staff	* 3 Core Mothers (newly hired)	This course was one of three growth and Development Courses taught by the NSSI administrative staff for Core Mothers' and other Community Child Case Workers Some sessions were done by outside professionals, EG. the nutritionist of the local WIC Program. The three Core Mothers who took the course were newly-hired and inexperienced. They used the course as part of their basic inservice.
WORKING WITH DIFFICULT FAMILIES	Presentation /Discussion	Focused on case studies presented by students for group discussion and problem solving	Fall 1978	5 sessions	CTR	* 4 Core Mothers (including 3 inexperienced Core Mothers)	Inexperienced Core Mothers felt that course was to unstructured and that the case study approach did not offer enough instruction. They, however, did not feel

NSSI STAFF TRAINING ACTIVITIES, 1976-1979
YEAR THREE

TRAINING ACTIVITY	TEACHING FORMAT	CONTENT	SEASON & YEAR	LENGTH	WHO TAUGHT	WHO ATTENDED	COMMENTS
							comfortable making constructive suggestions to increase the course's usefulness to them. This experience resulted in the program's attempt to have an administrative person take outside courses along with Core Mothers to work with them in keeping courses responsive.
Alcoholism: Exploration of the Issue and Attitude	Presentation/Discussion	See page 6 of this appendix	Fall 1978	4 Session plus required AA and Alanon Meeting	CASPAR	3 Core Mothers (inexperienced)	A repeat of the Course Offered in the Fall of Year Two.See page of this appendix.
INTRODUCTION COMPOSITION	Presentation/Discussion	Practice in writing resumes, case studies, and reports. Students encouraged to incorporate NSSI paper work into the course work.	Fall 1978	8 session	CTR	* 3 (inexperienced) Core Mothers	
HOMEVISIT OBSERVATION	observation/discussion	Newly hired Core Mothers observed experienced Core Mothers' homevisits then discussed it with them.	Fall 1978	6 homevisits	Experienced Core Mothers	* 3 Inexperienced Core Mothers	
Evaluating Child Progress, TADS Small Group Meeting (Nashville, Kentucky)	Presentation/Workshop		Fall 1978	3 days	TADS	Director	NSSI director was most interested in the notion of setting qualitatively different goals in different groups of client children, according to both

NSSI STAFF TRAINING ACTIVITIES, 1976-1979
YEAR THREE

TRAINING ACTIVITY	TEACHING FORMAT	CONTENT	SEASON & YEAR	LENGTH	WHO TAUGHT	WHO ATTENDED	COMMENTS
							the nature and severity of their disabilities
Seminar In The Development of Infants and Parent 3rd Annual Conference	lecture	Current research findings concerning parent-child interaction.	Fall 1978	2 days	Professionals involved in research	Director/Administrative Asst.	
Preventing Burn-Out	Presentation /Discussion	Techniques designed to aid people in service work keeping themselves from becoming overwhelmed and burnt out.	Fall 1978	1 day		OT/1 Core Mother	Information about this inservice was circulated in the NSSI office and it was elected by those staff members who felt they could personally benefit from it.
USING ROLE PLAY WITH CLIENTS	Presentation /Discussion Role Play Practice	Techniques of directness with clients, giving and receiving feedback, confrontation, compromise.	Fall/ Winter 1978-1979	4 sessions	Educational Consultant, through CTR	* NP/All Core Mothers	Designed by Administrative staff and consultant to give Core Mothers a positive experience with role play as a learning technique. Core Mothers discomfort with "pretending to be someone else" had kept them from using it. Core Mothers were all very positive about this inservice The 2-session original design was expanded to 4 sessions at their urging. Role play, however, continued to be a difficult technique for them to use.
NORMAL MOTOR DEVELOPMENT IN THE FIRST YEAR	Presentation /With Audio Visual Aid	Discription of normal reflexive and motor skills development using slides of normal infants to illustrate how these stages looked.	Winter 1979	2 hour sessions	Pre-School Unit, Physical Therapy Consultant, Mary Lou Jani	* All Staff	Seen as review for administrative and experience Core Mother staff. Useful to firs first year Core Mothers as a comprehensive introduction to motor development.

NSSI STAFF TRAINING ACTIVITIES, 1976-1979
YEAR THREE

TRAINING ACTIVITY	TEACHING FORMAT	CONTENT	SEASON & YEAR	LENGTH	WHO TAUGHT	WHO ATTENDED	COMMENTS
PROGRAM EVALUATION	Observation of homevisit by evaluator, administrative staff and Core Mothers of each other/ discussion of those homevisits and program itself.	Discussions based on homevisits focused on the role of the Core Mother Program evaluation discussions exhaustively covered all facets of the program's functioning ,services, philosophy, staff development, etc.	Fall 1978 to Spring 1979		Ann Coolidge, Program Evaluation Consultant	*All Staff participated	This evaluation was seen as inservice because it not only comprehensively evaluated NSSI but in doing so provided the Staff with insight into the program which led to changes being made. Client contact forms for instance, were improved and inservice during the final year focused more on the parent, once this evaluation revealed that it was the Mother rather than the child that this program was directly working with. Isolating the role of the Core Mother was seen as a key task for this evaluation. In the process what became clear was that the hiring was as if not more important than training, ie. no amount of inservice would prepare a Core Mother who did not already have the strengths and attitudes necessary for the job.
Visit to Boston City Hospital Early Intervention Program	Observation/ Presentation	Description of the program's services and observation of a clinical staff meeting and staff working with children in program playroom.	Fall 1978	1 day	Director of Program, Margaret Smith	Director/NP/2 Core Mothers	Staff was struck by the difference between this program and NSSI, EG. Work went on in one room and the staff was primarily professional.
BI-WEEKLY STAFF CASE STUDY	Presentation /Discussion	Description of family by Core	Winter 1979	4 2 hour sessions	Core Mother & Case Manager	*All Staff	This was started to encourage Core Mothers to not only

NSSI STAFF TRAINING ACTIVITIES, 1976-1979
YEAR THREE

TRAINING ACTIVITY	TEACHING FORMAT	CONTENT	SEASON & YEAR	LENGTH	WHO TAUGHT	WHO ATTENDED	COMMENTS
		Mother and Case Manager including: medical, social & developmental history and current status, goals and objectives in working with the family, and listing one or two problems to which suggestions sought.					present case studies but also clarify most important problems they were having with a family which they could throw out for the staff to problem-solve together. It proved to be hard for Core Mothers to ask for help by presenting problems which they needed suggestions. Group evaluation had just gotten to the point of selecting only families for case study who were presenting clear difficulties when other variables made continuing this training impossible
USE OF "PARENT BEHAVIOR PROGRESSION"	Presentation/ Discussion	Discription in use of PBP and group scoring of client families (mothers) using the tool.	Winter 1979	2 days	Rose Bromwich Developer of PGP and TADS-paid consultant	* All Staff	The staff gave up a holiday to come in for this workshop. While the administrative staff felt exhilerated by it and thought the discussion useful in looking at families Core Mothers were in general less positive. They did not like sitting and talking for two days straight. The PBP itself was not adopted for wide use in the program but did help in writing behavioral objectives for some Mothers having difficulty interacting with their child.

NSSI STAFF TRAINING ACTIVITIES, 1976-1979
YEAR THREE

TRAINING ACTIVITY	TEACHING FORMAT	CONTENT	SEASON & YEAR	LENGTH	WHO TAUGHT	WHO ATTENDED	COMMENTS
WRITING APPROPRIATE INTERVENTIONS FOR CHILDREN	Presentation/Discussion	Thinking systematically about what goes into writing an intervention: appropriatness of toy or activity, skills of child and parent, desired goal.	Winter/Spring 1979	weekly 2 hour sessions for 6 weeks	Occupational Therapist	* All inexperienced Core Mothers	This inservice was set up at inexperienced Core Mothers request for help with intervention writing both in being able to generate their own ideas and develop activities that were fun for the child. Core Mothers liked the sessions and interventions because more numerous as well as creative.
Managing Seizures (Children's Hospital - Developmental Evaluation Clinic Series)	lecture	Information about etiology, clinical picture, diagnosis and treatment of seizures.	Winter 1979	2 hour sessions	Neurologists from Children's Hospital	NP/2 Core Mothers	This was not found particularly helpful by any of the staff who attended. Core Mothers felt the information was to technical for their understanding. And the nurse practitioner felt it was focused mostly on school aged children. One of the Core Mothers who chose to go to this did so because one of her own children in the past had had seizures about which she had known very little. And the other Core Mother had a child in her caseload with a seizure disorder.

NSSI STAFF TRAINING ACTIVITIES, 1976-1979
YEAR THREE

TRAINING ACTIVITY	TEACHING FORMAT	CONTENT	SEASON & YEAR	LENGTH	WHO TAUGHT	WHO ATTENDED	COMMENTS
Improving Home-visiting Skills	Presentation/ Discussion Role Play	Participant introductions of experience with homevisiting and goals for course, role play of situations in homevisiting with feedback often words.	Spring 1979	4 2 hour sessions	CTR	NP/3 inexperienced Core Mothers	Participants felt the course was somewhat too unstructured and did not offer enough concrete information though they learned from the role play experience. The nurse practitioner took the course along with Core Mother's as with program decision to give Core Mothers help in making inservices useful to them. She was, however not able to help restructure the course, because it was too short (with only four sessions) and because other course participants with less homevisiting experience found it appropriate for their needs.
Premature Parents Program, Lowell Mass.	Visit	Discussion with Program Staff	Spring 1979	1 day	PPP Staff	Administrative Assistant/ Director	Useful information about outreach to potential client.
FAILURE TO THRIVE	Presentation with questions and answers	Information on clinical definition of failure to thrive, prognosis, and family treatment.	Spring 1979	2 hour sessions	Dr. Dan Rosen, Clinician and researcher in failure to thrive	* All Staff	This inservice was arranged by the program's parent coordinator in response to a number of informal office discussions about the issue and case studies around client families.

NSSI STAFF TRAINING ACTIVITIES, 1976-1979
YEAR THREE

TRAINING ACTIVITY	TEACHING FORMAT	CONTENT	SEASON & YEAR	LENGTH	WHO TAUGHT	WHO ATTENDED	COMMENTS
Working with Young Children (Mass Department of Public Health Sponsored)	lecture	Sessions gave information on prenatal risk factors. Assessment of the newborn, abuse and neglect, seizure disorders, congenital heart disease. Normal development in the first two years.	Spring 1979	4 weeks 2 hour sessions	Nurses and Professionals	NP	The nurse practitioner took this series because she felt there would be medically based information that she could apply to NSSI services. The course geared to participant public health and school nurses who had little experience with children under age 3. And she found information on the medically at risk child most useful, the normal growth and development information not in depth enough for her needs.
Youville Series	lecture	Highly specific medical information about cardiac anomalies visual and hearing problems	Spring 1979	5 2 hour sessions	Local Medical Specialists	Director/NP	Individuals presentations of interest with little carry over to program implementation.
Parent Aide Conference (Mass Office for Children)	lecture/ workshop	Discription of a number of parent aid programs in this state and others, workshops covering related issues like funding, philosophy, etc.		1 day	Director of Parent Aide Programs, State and private sector. Professionals with interests in Parent Aide Programs.	Director/NP	Because NSSI's continuation funding would be unlikely to come from early intervention monies, the program had to make funding contacts in related networks. Parent Aide Programs seemed appropriate. A film of parent aides from a program in Syracuse, New York was particularly exciting and the administrative staff

NSSI STAFF TRAINING ACTIVITIES, 1976-1979
YEAR THREE

TRAINING ACTIVITY	TEACHING FORMAT	CONTENT	SEASON & YEAR	LENGTH	WHO TAUGHT	WHO ATTENDED	COMMENTS
							who attended and saw it felt NSSI Core Mothers would have identified with and enjoyed it.
Western Mass Training Consortium Annual Symposium	Lecture	Information on a variety of issues including: Abuse and neglect, lead paint poisoning, infant temperment, and the Denver Developmental Screening Test.	Spring 1979	1 day	Physicians, including Eli Newberger, and William Carey	Director/NP/ Administrative Assistant/1 Core Mother	Well presented and interesting information, least enjoyed by Core Mothers who found the lecturing difficult to sit through. William Careys' presentation on his infant temperment scale was especially interesting and it was worked at more closely though not instituted in NSSI.
ADMINISTERING THE BRAZELTON NEONATAL BEHAVIORAL ASSESSMENT SCALE	Observation of test being administered by a Brazilton Unit Trainer	Bulk of learning went on through practice of administering the scale to neonates at Cambridge Hospital	Spring 1979		Brazilton Unit trainer, Kevin Nugent	Director/NP	The purpose of doing this rather unique inservice was threefold. One to gather credentials and skills. Two, interest in neonates and better understanding of them for application to NSSI client And three, to establish a presence at Cambridge Hospital to encourage referrals from hospitalpersonnel to NSSI. The end goal of this training was to become certified in administering the scale.

NSSI STAFF TRAINING ACTIVITIES, 1976-1979
YEAR THREE

TRAINING ACTIVITY	TEACHING FORMAT	CONTENT	SEASON & YEAR	LENGTH	WHO TAUGHT	WHO ATTENDED	COMMENTS
CONVERSATIONAL PORTUGUESE	one to one tutoring	Elementary conversational Portuguese concentrated around practice with simple role play of talking with a mother about her infant.	Spring 1979	10 2 hour sessions	Portuguese Immigrant and Teacher	NP	The primary purpose was to improve the nurse practitioner's spoken Portuguese to aid her in describing the Brazelton Scale to Portuguese immigrant mothers to get their permission to perform it on their neonates.

Referral Sources for Accepted Cases, NSSI
12/1/76 - 6/31/79

Somerville Hospital, Division of Community Health (Most referrals came from Somerville Pediatrics, but several came from the Women's Clinic and from neighborhood-based satellite clinics. All were out-patient.)	21
Self-referrals	19
Cambridge Hospital, Division of Social Services (All referrals were in-patient.)	6
PreSchool Unit, Somerville-Cambridge Mental Health and Mental Retardation Association	6
Massachusetts Department of Public Welfare, Somerville Office	5
Somerville Mental Health Association	4
Catholic Charities Bureau of Cambridge and Somerville	3
Children's Hospital Medical Center (Boston)	2
Helping Out in the Parenting Experience (HOPE)	2
Somerville Headstart/Daycare	2
Somerville Portuguese-American League	2
Boston Family Services	1
Brockton Multi-Service Center	1
Cambridge Family and Children's Services	1
DARE Multi-Service Program, Somerville	1
Floating Hospital, Intensive Care Unit	1
HELO (Helping Exceptional Little Ones)	1
Massachusetts Department of Public Welfare, Central Office	1
Massachusetts General Hospital, Dept. of Social Services	1
Medford EMOC (Eastern Middlesex Opportunities Council)	1
Medford Pediatrics	1
RESPOND	1
Tri-City Early Intervention Program	1